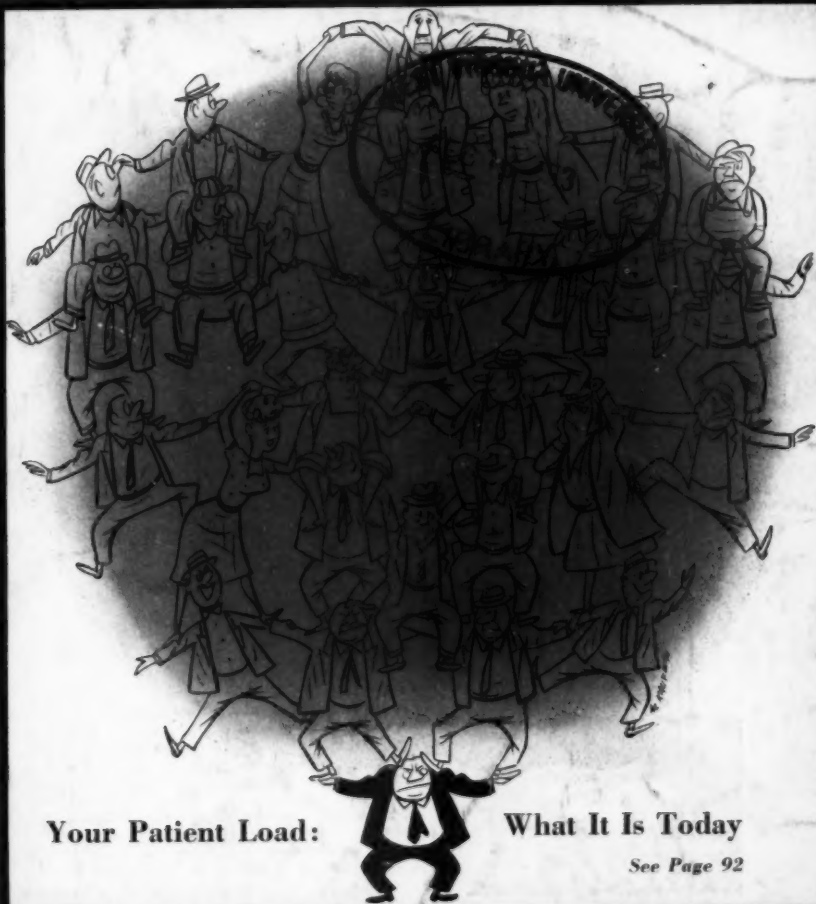


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February Medical Economics



Your Patient Load:

What It Is Today

See Page 92

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MEDICAL CENTER

Safe, gradual, prolonged vasodilation

Isn't that
what you want
for your
hypertensive
patients?



Nitranitol provides it . . . permitting hypertensives to resume more normal lives.

And . . . therapeutic dosages of NITRANITOL can be maintained over long periods of time . . . without frequent checkups . . . without worry about possible toxic effects.

Nitranitol is the universally prescribed drug in the management of essential hypertension.

NITRANITOL[®]

(brand of mannitol hexanitate)
FOR SAFE, GRADUAL, PROLONGED VASODILATION



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2. When sedation is desired—NITRANITOL with PHENOBARBITAL.
3. For extra protection against hazards of capillary fragility—NITRANITOL with PHENOBARBITAL and RUTIN.
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5. For refractory cases of hypertension—NITRANITOL P.V. (Nitranitol, Phenobarbital, Veratrum Alkaloids*)

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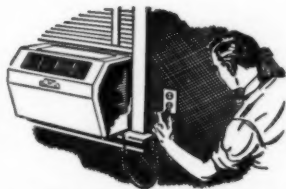
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MITCHELL
room
air
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Get the newest—get
the most—get all the automatic
comfort features you get in genuine
hotel and theatre air conditioning
for as little as \$**229⁹⁵**

ON EASY
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*Just slide it in your window - Just plug it in your outlet.
No fuss - No muss - No plumber*

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"OUR 25th YEAR"

THE MEDICAL ARTS SUPPLY CO.

706-10 Fourth Avenue

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*...the most widely accepted
professional bag on the market today*

The EMDEE bag is especially styled both inside and out for both modern appearance and practicability. Compartments in the divided top are arranged so that a blood pressure instrument of most any type can be carried on one side; the other side is divided in the center for gauze, bandages, hypodermics, small bottles, etc. The bottom compartment has adjustable bottle loops on one side. Case is fully lined with washable plastic coated fabric.

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features:*

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- Maximum Convenience
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- Extra Large Capacity
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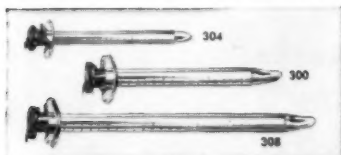
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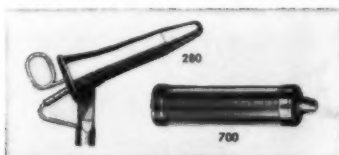
THIS COMPLETE WELCH ALLYN RECTAL SET

**fills every need of
specialist or GP**

The importance of *complete* rectal examination to detect possibly precancerous lesions or abnormalities is now widely recognized, and more and more physicians are equipping themselves with rectal instruments. General practitioners are learning what proctologists have long known: that Welch Allyn rectals are superbly designed and made for efficient diagnosis and treatment, ease of use and durability. A particular favorite is this No. 318 set, priced at \$169.50, whose contents are shown in detail below.



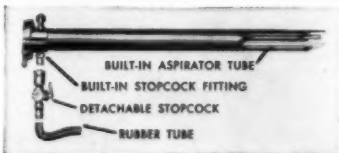
No. 308 sigmoidoscope, No. 300 proctoscope and No. 304 infant proctoscope, distally illuminated for brilliant, glare-free field of view, with tapered and curved obturator tips for easy passage.



No. 280 medium anoscope, with brilliant, shadow-free illumination, offset obturator handle. No. 700 large battery handle, with rheostat control, a dependable source of current for all Welch Allyn instruments.



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Welch Allyn sigmoidoscopes are available at \$10.00 extra per instrument with built-in aspirator tube for smoke removal, complete with stopcock as shown in exploded view, above.

Set No. 318 also includes inflating bulb and cord (for attachment to battery handle, battery box or transformer) and extra lamps. Smaller Welch Allyn rectal sets are also available, and individual instruments may be purchased separately.

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PEL-TONER *works miracles*



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Medical Economics

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in the hands of the physician

Often the critical evaluation of the drug to be administered is as important to the patient's recovery as is the diagnosis of his condition. In each case correct procedures can be determined only by the physician.

CHLOROMYCETIN is eminent among drugs at the disposal of the medical profession. Clinical findings attest that, in the hands of the physician, this widely used, broad spectrum antibiotic has proved invaluable against a great variety of infectious disorders.



Chloromycetin®

notably effective
well tolerated
broad spectrum antibiotic

The many hundreds of clinical reports on CHLOROMYCETIN emphasize repeatedly its exceptional tolerance as demonstrated by the infrequent occurrence of even mild signs and symptoms of gastrointestinal distress and other side effects in patients receiving the drug.

Similarly, the broad clinical effectiveness of CHLOROMYCETIN has been established, and serious blood disorders following its use are rare. However, it is a potent therapeutic agent, and should not be used indiscriminately or for minor infections—and, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in a variety of forms, including:

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CHLOROMYCETIN Capsules, 100 mg., bottles of 25 and 100.
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CHLOROMYCETIN Ophthalmic Ointment, 1%, ¼-ounce collapsible tubes.
CHLOROMYCETIN Ophthalmic, 25 mg. dry powder for solution,
individual vials with droppers.



Parke, Davis & Company



ganglionic block in hypertension

to reduce blood pressure and relieve symptoms—a new, potent oral hypotensive

Extensive clinical use has demonstrated Methium's ability to

1. reduce blood pressure to more normal levels
2. relieve hypertensive symptoms
3. provide symptomatic relief in some cases even where pressure cannot be lowered.

An autonomic ganglionic blocking agent, Methium (*hexamethonium chloride*) inhibits nerve impulses that produce vasoconstriction—thereby causing blood pressure to fall.

In successfully treated patients, receding pressure is accompanied by relief of head-

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Methium is a potent drug and should be used with great caution when complications exist—impaired renal function, coronary artery disease and existing or threatened cerebral vascular accidents. Complete instructions for prescribing Methium are available on request and should be consulted before using the drug.

Methium is supplied in both 125 mg. and 250 mg. scored tablets in bottles of 100 and 500.

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(BRAND OF HEXAMETHONIUM CHLORIDE)

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THE PRACTICABLE SOLUTION OF

A patient on Obedrin Tablets can maintain a restricted diet, in comfort and lose excess weight fairly rapidly, without undesirable side effects.

Each Obedrin Tablet contains:

SEMOXYDRINE HYDROCHLORIDE, 5 mg.
(Methamphetamine Hydrochloride)
Suppresses appetite, elevates mood.

THIAMINE HYDROCHLORIDE, 0.5 mg.;
RIBOFLAVIN, 1 mg.; NIACIN, 5 mg.
Dose of these essential vitamins is adequate to supplement the 60-10-70 Diet, yet low enough to prevent stimulation of appetite.

ASCORBIC ACID, 100 mg.
A large dose, to help mobilize tissue fluids, so often a problem in obese patients.

PENTOBARBITAL, 20 mg.
To avoid excitation and insomnia; counteracts undesirable cerebral stimulation of methamphetamine. Does not diminish the anorexigenic action of methamphetamine.

A complimentary pad of 60-10-70 Basic Diet Sheets and a trial supply of Obedrin sent to physicians on request.

obesity control



S.E. Massengill

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AND THE
60-10-70 BASIC DIET

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*In specified territory.

From where I sit by Joe Marsh



Bunny's Story Had a Nice "Ring" to It

"Bunny" Baker—our cute blonde secretary over here at the newspaper—showed up a half-hour late for work last Wednesday morning and "scooped" us all.

Bunny came in carrying a big box of cigars under her arm and, without a word, went around dropping a cigar off at each desk. Finally, when we were all but bursting with curiosity, Bunny told us what was going on. She held up her left hand and proudly displayed a lovely diamond ring on her third finger.

"It's a boy," she said. "Six feet two, a hundred ninety-six pounds."

From where I sit, Bunny's way of announcing her engagement showed real ingenuity. And ingenuity—doing things in a better and different way—is a typical American trait. Freedom of expression, freedom to work how and where we please... even the freedom to choose a glass of beer after a day's work—these are some things that make our nation so "engaging."

Joe Marsh

Announcing Dodekroid

*for the child
whose mother
complains
"He's not growing
the way he should"*

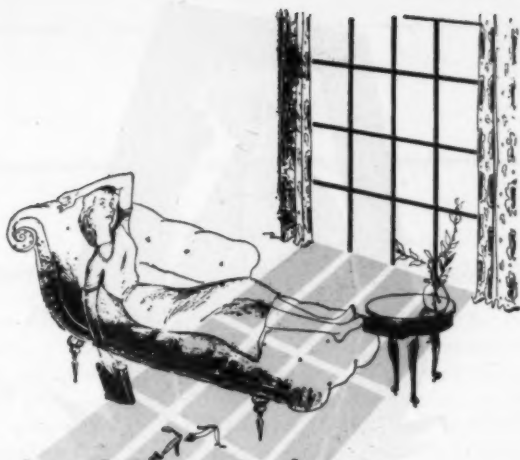


Each Dodekroid tablet provides 10 mcg. of vitamin B₁₂ (activity equivalent) and 10 mg. of thyroid substance. The tablets are small and easily swallowed, or may be chewed, or crushed for administration with food. Literature and samples on request.

Dodekroid combines the two metabolic stimulants found of value in overcoming simple growth failure—vitamin B₁₂ and thyroid substance. In the absence of detectable glandular dysfunction or infectious processes, such growth failure responds well to Dodekroid. Vitamin B₁₂ mobilizes the many metabolic processes involved in growth promotion, and thyroid substance, in the small quantity provided, exerts a well-established anabolic effect, increasing growth rate and physical development. Masked or subclinical hypothyroidism is also corrected.

Response to Dodekroid is usually rapid and at times spectacular. Daily dosage ranges from 1 to 3 tablets, preferably after meals. If mild hypothyroidism is suspected, dosage may be increased.

RIKER LABORATORIES, INC., 8480 Beverly Boulevard • Los Angeles 48, California



when she's Imprisoned by **FATIGUE**

... you may free her from iron-deficiency anemia by the simple expedient of prescribing one **IBEROL** tablet t.i.d.

As you can see by the formula, three **IBEROL** tablets provide a therapeutic dose of iron plus seven B complex factors including **B₁₂**. In addition, **IBEROL** supplies standardized stomach-liver digest and ascorbic acid.

Compressed, triple-coated **IBEROL** tablets are easy to take with no trace of liver odor or taste.

The outer sugar-coating masks the iron, gives the tablet a pleasant odor and flavor.

For prophylaxis in pregnancy, old age or convalescence, one or two tablets are usually enough. May be used as a supplemental hematinic in pernicious anemia. **IBEROL** is available in bottles of 100, 500 and 1000. **Abbott**

THREE IBEROL TABLETS: the average daily therapeutic dose for adults, supply:

Ferrous Sulfate 1.05 Gm.
(representing 210 mg. elemental iron, the active ingredient for the increase of hemoglobin in the treatment of iron-deficiency anemia)

Plus these nutritional constituents:

Thiamine Mononitrate (5 times MDR*) 5 mg.
Riboflavin (5 times MDR*) 5 mg.
Nicotinamide (5 times MDR*) 30 mg.
Ascorbic Acid (5 times MDR*) 150 mg.
Pyridoxine Hydrochloride 3 mg.
Pantothenic Acid 5 mg.
Vitamin B₁₂ 30 mcg.
Folic Acid 2.5 mg.
Stomach-Liver Digest 1.5 Gm.

*MDR—Minimum Daily Requirement
RDA—Recommended Daily Dietary Allowance

prescribe

IBEROL

(Iron, B₁₂, Folic Acid, Stomach-Liver Digest,
With Other Vitamins, Abbott)

double the power

to resist food
in
obesity



Obocell® controls the two causes directly responsible for overeating—bulk hunger and appetite.

Obocell supplies non-nutritive bulk to create a sense of fullness and satisfaction.

Obocell

A COMBINED HUNGER AND APPETITE DEPRESSANT

Curbs the appetite at its source by acting on the central nervous system, and concomitantly elevates the mood of the overweight patient.

With Obocell it is easy to achieve and maintain patient co-operation throughout the trying period of weight reduction by dietary restriction.

Composition: Each tablet Obocell contains Dextro-Amphetamine Phosphate 5 mg.; *Nicel 150 mg.

Dosage: 3 to 6 tablets daily, preferably one hour before meals with a full glass of water.

Supplied: In bottles of 100, 500, 1000 tablets.

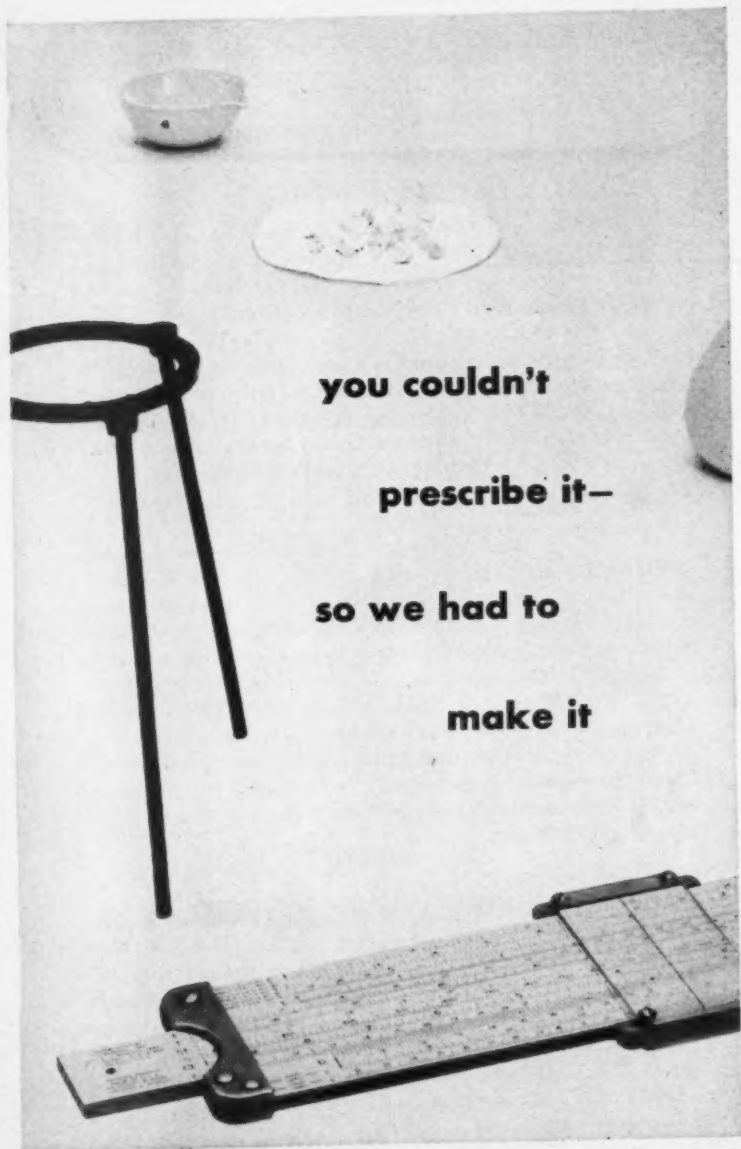
*Nicel-Heidel's Brand of High-Viscosity Methylcellulose.

Panorama

Other folks' insurance helps doctors too: Insurance companies paid 152,000 private physicians a total of \$338 million for services rendered in 1951, according to a recent survey. The figure is said to represent 13 per cent of the doctors' income . . . Ethics-flouting has lost an ardent exponent with the death of Painless Parker, San Francisco's honky-tonk dentist. He used to pull teeth publicly on the sidewalk, drumming up crowds with brass bands, dancing girls, and a circus . . . Was it defeatism or escapism that led the American Cancer Society's Arizona Division to hold its latest meeting at Phoenix's Paradise Inn?

The lay press spoons out medical reading matter to 100 million Americans a week, estimates William T. Doyle, vice president of Organon Inc. He's counted an average aggregate of eleven medical stories a day in three big newspapers, forty-three medical articles a month in big-circulation magazines . . . Almost 8,000 physicians have drawn pay checks from the United Mine Workers in the past three years. They've treated miners under the union's \$50-million-a-year medical program . . . At least fifteen state legislatures are mulling over plans for cash benefits to employed persons during temporary illness. Such plans already help pay doctor bills in New York, New Jersey, Rhode Island, and California.

When staff doctors at Freedmen's Hospital (Washington, D.C.) relieved a patient of a three-inch knife blade embedded in his stab wound, he sued for damages—and won. Reason: The blade hadn't been found six weeks earlier, when the wound was first treated . . . Fee-basis physicians participating in the V.A. home-town care program must now ration services to veterans. They've been asked to give priority to urgent cases, because budget cuts prevent payment for treatment to all.



you couldn't

prescribe it—

so we had to

make it

Doctors have always wanted a formula for infant feeding that would be as close to human milk as nutritional science could provide.

The problem was immense; the requirements were rigid; the need was great. Borden took up the challenge, and after years of research and many trials and clinical tests the goal was accomplished. BREMIL was made available to the profession.

BREMIL is the first and, to date, the *only* infant food to achieve all of these prescription requirements:

- ... conforms to the fatty acid pattern of human milk
- ... conforms to the amino acid pattern of human milk
- ... has a calcium-phosphorus ratio (guaranteed minimum 1½:1) adjusted to the pattern of human milk to prevent tetany
- ... supplies the same carbohydrate as human milk - lactose
- ... is vitamin-adjusted for standards of infant nutrition
- ... offers a human milk size particle curd
- ... is well-tolerated, digested, assimilated

COSTS NO MORE PER DAY THAN ORDINARY FORMULAS
REQUIRING VITAMIN ADJUSTMENT

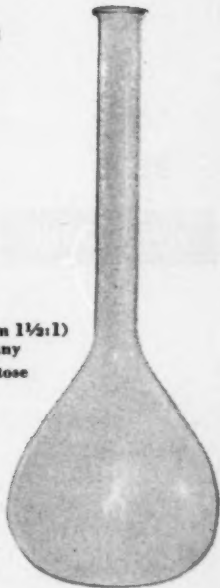
Bremil[®] powdered infant food



Approximates the milk of the mother

Clinical reference data and samples on request.
Now in drug stores in 1 lb. cans

The **Borden** Company, 350 Madison Ave., New York 17
Prescription Products Division



**SHE'S
BEEN**

HYFRECATED

**not a
blemish
on her...**



Desiccate those unsightly, possibly dangerous, skin growths with the ever-ready, quick and simple-to-use Hyfrecator. 90,000 instruments in daily use.



Please send me your new four-color brochure showing step-by-step technics for the removal of superficial skin growths.

Doctor _____

Address _____

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teaspoon dosage

good taste

effective therapy

containing
Terramycin

suspension
FLAVORED

Supplies 250 mg
of pure crystal-
line Terramycin
in each palatable
and convenient
teaspoonful —
unexcelled for
patients young
and old.

Pfizer

*BRAND OF OXYTETRACYCLINE, AMPHOTERIC

DON'T MISS



APPEARING REGULARLY IN THE J. A. M. A.

new

2

more potent members of the Es

'Eskacillin 500'

palatable liquid penicillin

S.K.F. now offers 'Eskacillin' in a new, higher concentration:
one-half million units of procaine penicillin G per teaspoonful.

'Eskacillin 500' gives you these advantages:

1. Greater effectiveness in the more severe infections.
2. The convenience of b.i.d. or t.i.d. dosage.
3. Unusual palatability—despite high potency.

'Eskacillin 250'

'Eskacillin 100'

'Eskacillin 50'

the *Eskacillin** line—for use in the more severe infections:

'Eskacillin 250-Sulfas'

palatable liquid penicillin plus sulfonamides

Each teaspoonful of 'Eskacillin 250-Sulfas' delivers 250,000 units of procaine penicillin G *plus* 0.5 Gm. (0.167 Gm. each) of 3 sulfonamides (sulfadiazine, sulfamerazine, sulfamethazine), thus permitting convenient t.i.d. dosage.

'Eskacillin 250-Sulfas' gives you 3 advantages over penicillin or the sulfonamides alone:

1. Wide antibacterial spectrum.
2. High antibacterial intensity.
3. Lessened chance of the development of resistant strains.

'Eskacillin 100-Sulfas'

Smith, Kline & French Laboratories, Philadelphia



TURICUM[®]

**PHYSIOLOGIC
CONSTIPATION
CORRECTIVE**

**sodium carboxy-
methylcellulose and
magnesium hydroxide**

**assured hydration
throughout the
gastrointestinal tract**

With the ever-increasing trend toward more normal elimination methods, sodium carboxymethylcellulose has been established as a reliable, physiologic constipation corrective.

Turicum presents sodium carboxymethylcellulose as a fluid gel—providing soothing *lubricoid action* in its hydrated form. To assure continued hydration throughout the bowel, magnesium hydroxide is added in less than laxative dosage.

Clinical evidence shows that sodium carboxymethylcellulose has greater hydrophilic potential in gel form; it mixes

more readily with the intestinal contents and possibilities of bloating and impaction, common with the dry product, are eliminated.

**smooth, demulcent,
pleasantly flavored**

With Turicum there is none of the messiness and disadvantages of powders and oils; no elaborate mixing procedures; no unpleasant grittiness; no absorption of vitamins. One or two tablespoonfuls a day will start the chronically constipated patient on an effective program of correction.

This simplified, more convenient dosage schedule and Turicum's smooth, mint flavor assure better patient cooperation and more satisfying results.

formula:

Each tablespoonful (15 cc.) contains:

Sodium Carboxymethylcellulose.....0.36 Gm.

Magnesium Hydroxide.....0.6 Gm.

Whittier

LABORATORIES

Chicago 11, Illinois

A Division of Nutrition Research Laboratories, Inc.

pint bottles

joint and muscle pain relieved with

supplies:

methacholine chloride 0.25%

thymol 1%

1-oz. tubes and 8-oz. jars.

arthralgesic unguent

methyl salicylate 15%—menthol 10%

When a patient
won't hear of giving up coffee...



Medical drawing reproduced from
"Gray's Anatomy" by permission
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Tell him about grand-tasting Sanka Coffee.
It's 97% caffeine-free... can't cause sleep-
lessness or get on the nerves.

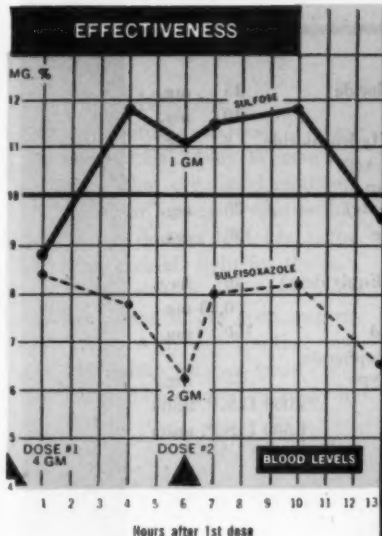
SANKA

The perfect coffee for the
patient affected by caffeine.



Products of General Foods

why SULFOSE for sulfonamide therapy



- Higher, better sustained blood levels
- Superior tissue distribution
- Additive action against sulfonamide-sensitive organisms
- Fewer daily doses

SUSPENSION

SULFOSE®

TRIPLE SULFONAMIDES
WYETH

SUPPLIED: Bottles of 1 pint:
Each teaspoonful (5 cc.) supplies 0.5 Gm. total sulfonamides (0.167 Gm. each of Sulfadiazine, Sulfamerazine and Sulfamethazine) in a special alumina gel suspension
Also available: Tablets SULFOSE, 0.5 Gm.; bottles of 100





Thiamin Chloride	15	mg.
Riboflavin	10	mg.
Pyridoxine Hydrochloride	3	mg.
Pantothenic Acid (as Calcium Pantothenate)	20	mg.
Nicotinamide	150	mg.
Vitamin B ₁₂ (Activity Equivalent)	10	mcg.
Folic Acid	0.33	mg.
Ascorbic Acid	150	mg.
Distilled Tocopherols, Natural Type	25	mg.
Vitamin A	25,000	U.S.P. units
Vitamin D	1,500	U.S.P. units

*No fishy
aftertaste*



*A complete, highly potent vitamin combination,
indicated when the need is acute*

CELSEALS

Theracebrin

(PAN-VITAMINS, THERAPEUTIC, LILLY)

Speaking Frankly

Czar for Medicine?

Sirs: According to one of your news items, Dr. Miley Wesson has suggested that organized medicine hire a "Czar"—a man who would fight for the doctors' interests, as the great labor chiefs fight for theirs. I second the motion. We need more decisive action in our economic relationships with one another and with the public. Miley Wesson's proposal should be studied seriously by the A.M.A.

M.D., Washington

Sirs: ... My God, no! Not another Fishbein!

M.D., New Jersey

Doctor Draft

Sirs: I'm an Army physician. I was "volunteered" into the service in 1950.

The real purpose of the doctor-draft law, as I see it, is to provide the Army with a cheap source of medical labor.

Instead of granting medical care allotments to service personnel so they can pay for private care, the Army saves money by drafting doctors. Yet, 70 per cent of present Army medical care is given to soldiers in the United States, and to

the dependents of soldiers here and abroad.

There's an easy alternative to the doctor draft: Let the Army provide its enlisted personnel with some kind of insurance similar to workmen's compensation. Private physicians would then treat soldiers and their dependents, and they would collect from the Government according to a predetermined fee schedule. The Regular Army Medical Corps would, of course, continue to care for Army personnel and their families abroad.

Captain, M.C., New York

Sirs: Thank Heaven, Dr. Stanley Orloff [November issue, page 68] isn't typical of the physicians facing induction into the United States armed forces! By his refusal to answer questions on a loyalty questionnaire, he has disqualified himself for military service. He should not be allowed to serve this country in *any* such capacity.

Daniel D. Lovelace Jr., M.D.
Dubuque, Iowa

Mutual Funds

Sirs: The author of "Don't Go Overboard on Mutual Funds" says that the 8 per cent acquisition cost of mutual funds contrasts unfavorably

In the Treatment of

NEURITIS

(Sciatic—Intercostal—Facial)

"...patients responded
with complete relief
of pain"*

WITH **PROTAMIDE**



* Richard T. Smith, M.D., in a currently published paper, "Treatment of Neuritis with Protamide" reports: 84 patients of 104 had complete relief of pain in sciatic, intercostal and facial neuritis with one daily injection of Protamide for five or ten days. "... 49 were discharged as cured after five days of therapy." No intolerance to Protamide, systemic or local was found in the 125 patients (104 plus 21 controls). Two qualifications for practical application of this study are:

1. The elimination of cases due to mechanical pressure.
2. Early treatment after onset.

Your prescription
blank marked
PROTAMIDE
REPRINT
will bring literature.

SHERMAN LABORATORIES
BIOLOGICALS • PHARMACEUTICALS

WINDSOR

DETROIT 12, MICH.

LOS ANGELES

with the acquisition cost of individual securities. He is talking, of course, about buying such individual securities in 100-share lots. Yet most people buy in smaller lots; and here, percentagewise, the cost goes up.

To buy and sell fifteen shares of a listed security quoted at \$15 per share will cost \$18.50, or 8.1 per cent. If you buy stocks listed in the over-the-counter market, you'll pay even more.

Bear in mind that in either case, you end up with just one security. It may be a good security today; but only continuous supervision, such as a mutual fund provides, will keep you on the safe side.

If you wish to diversify \$10,000 among fifty listed securities, it will cost you 8.8 per cent. If you have a larger sum, say \$50,000, it will cost you only 5.4 per cent. But you can put that same amount into a mutual fund, with diversification of over 300 securities, for only 5 per cent.

So much for the cost argument.

The author questions the flexibility of large mutual funds in a time of crisis, implying that there will be heavy demands upon them. Yet consider the two weeks following the outbreak of the Korean war, when the stock market broke sharply under heavy selling:

In that period, Massachusetts Investors Trust, largest of the common stock funds, reported that its sales of new shares exceeded its liquidation of old shares—by 13 per cent. Keystone Custodian Funds'

sales exceeded liquidations by 64 per cent. And new share sales of Wellington Fund, the largest balanced fund, exceeded liquidations by a fantastic 550 per cent!

When the going got rough and *individual securities* were being unloaded in record volume, people turned, *to*, not *from*, the mutual funds.

Norman F. Dacey
Financial Consultant
Bridgeport, Conn.

Charity, Ltd.

SIRs: Taking from the doctor all direct exercise of judgment, our county welfare society has issued a directive limiting the number of calls to be made on welfare patients. The physician is permitted to make three calls a week on patients in hospitals, only one call a month on patients in nursing homes. Home and office calls for chronic cases are limited to one a week.

If the doctor believes additional calls are necessary, he must fill out an official form or make arrangements with the welfare department in advance. And he is directed not to call on patients *at all*, unless asked to do so by the patient, his family, a friend, a neighbor, or the department.

I've always tried to give my welfare patients at least as good care as I give my private patients. The welfare department, on the other hand, apparently believes that recipients of charity should have cheaper medicine and fewer visits

more

assured

THE ADVANTAGE OF COMPLETE COATING

Type of Coating		Advantages	
1. Full coverage	100%	1. Full coverage	100%
2. Full coverage	100%	2. Full coverage	100%
3. Full coverage	100%	3. Full coverage	100%
4. Full coverage	100%	4. Full coverage	100%
5. Full coverage	100%	5. Full coverage	100%
6. Full coverage	100%	6. Full coverage	100%
7. Full coverage	100%	7. Full coverage	100%
8. Full coverage	100%	8. Full coverage	100%
9. Full coverage	100%	9. Full coverage	100%
10. Full coverage	100%	10. Full coverage	100%

with this
new
therapeutic
combination

White's

A-P-Cillin

A recent clinical evaluation* of the effectiveness of certain drug combinations in acute upper respiratory infections, including the "common cold", clearly demonstrated A-P-Cillin to be, by far, the superior preparation.

It was found that 97.5% of the patients receiving A-P-Cillin were completely asymptomatic or improved at the end of the 72 hour treatment period.

Other commonly used preparations brought only 54% and 47% relief by the end of the same period.

To relieve distressing nasopharyngeal and constitutional symptoms, and to prevent secondary upper respiratory complications, prescribe—

White's A-P-CILLIN

Each tablet contains:

Procaine Penicillin G	100,000 units
APC { Acetylsalicylic acid	2½ gr.
{ Phenacetin	2 gr.
{ Caffeine	½ gr.
Phenyltoloxamine Dihydrogen Citrate (antihistamine)	25 mg.

Dosage: 2 tablets, t.i.d. for the duration of symptoms, preferably administered at least one hour before or two hours after meals.

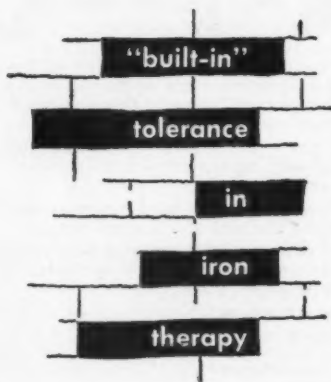
White Laboratories, Inc., Kenilworth, N. J.

*McLane, R. A.: Clinical Evaluation of Combined Drug Therapy in Acute Upper Respiratory Infections, J. M. Soc. N. J. 49:509 (Dec.) 1952.

IN BORDERLINE AND
IRON DEFICIENCY ANEMIAS



Irocine*



Minimum side effects
Irocine—only 2.1%
Ferrous Sulfate—20%

*Iron Sodium Malate with
catalyzing elements.



A PRODUCT OF REED & CARNRICK
JERSEY CITY 6, N. J.

A trusted name since 1860

from the doctor—in other words, inferior medical care.

Mark L. Herman, M.D.
Adams, N.Y.

When Discard Records?

SIRS: How long should a doctor keep copies of letters to patients about benign or malignant pathological reports?

J. P. Berger, M.D.
Wichita, Kan.

Such records should be kept until any possibility of a malpractice suit has been obviated by the statute of limitations in the physician's state. (Keep in mind, incidentally, that the statute doesn't usually begin to operate for children until they've reached their majority.)

A.A.G.P. Replies

SIRS: "M.D., Illinois," who criticizes the A.A.G.P. in a recent issue of your magazine, could not wander further from the truth and stay within the realm of plausibility.

His allegation that academy officials tried to sabotage the A.M.A. interim session two years ago is wholly unfounded in fact. The academy has helped promote the A.M.A. Interim Session and at its own expense has sent the A.M.A. program announcements to all its members.

Nor did the academy's representatives lobby to have the academy made a sponsor of the new joint accreditation program for hospitals. The fact is that the A.A.G.P. encouraged the A.M.A. to take over

hospital accreditation. The academy contends that no other organization, including the academy, should assume a responsibility that concerns all doctors.

It would be unfortunate if such fanciful statements upset the close and cordial cooperation that now exists between the A.M.A. and the A.A.G.P.

Mac F. Cahal, Exec. Secretary
Amer. Academy of Gen. Practice
Kansas City, Mo.

SIRS: Your uninformed and misinformed M.D. from Illinois is cordially invited to attend the St. Louis meeting, on March 22, of the Congress of Delegates of the A.A.G.P. There's nothing wrong with him that a little education won't cure.

J. S. DeTar, M.D.
Speaker, Congress of Delegates
Amer. Academy of Gen. Practice
Milan, Mich.

SIRS: One of your recent correspondents maintains that the G.P. doesn't need a big organization to protect his interests. The G.P., says the writer, has always been a great force in American medicine and will continue to be one.

Apparently, your correspondent is out of touch with recent developments in medical practice. Medicine is becoming as compartmentalized as the building trades, with the G.P. relegated to the status of unskilled laborer—a hewer of wood and a drawer of water for the specialist.

[MORE→]



Unlike other widely employed nasal vasoconstrictors, ARAMINE may be relied upon to relieve nasal congestion before retiring or during the night. Since ARAMINE apparently does not stimulate the central nervous system, it should not interfere with sleep.

Latest Development in Intra-Nasal Therapy



Gentle-acting ARAMINE may be administered safely to patients of all ages. Its use effectively shrinks engorged mucosa, permitting easier and more normal breathing, and facilitates drainage of excess fluids and debris.

Compare 'ARAMINE' with other nasal decongestants

Attribute	'ARAMINE'	EPHEDRINE	COMPOUND A
Duration	Moderate	Moderate	Protracted
Nasal damage from prolonged use	No	Occasionally	Occasionally
Irritation (stinging)	Virtually none	Yes	Virtually none
Secondary engorgement	Virtually none	Occasionally	In some patients
Excitation or insomnia	No	Yes	No
Palpitation	No	Occasionally	?
Inhibition of ciliary motility	Mild	Marked	Mild

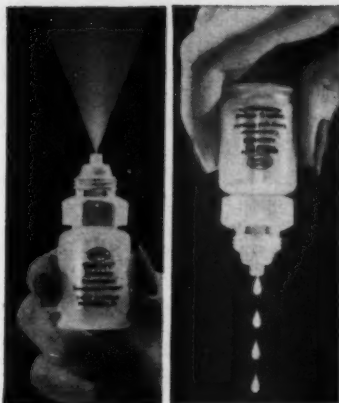
A development of the Sharp & Dohme Medical and Research Divisions, ARAMINE is the first new nasal vasoconstrictor of any consequence to be introduced to the medical profession in more than a decade.

ARAMINE IS AN EXCEPTIONALLY EFFECTIVE,
GENTLE-ACTING NASAL DECONGESTANT

Many nasal decongestants currently being used may actually aggravate symptoms—due to an inherent vasodilating component, or because their vasoconstrictor action is so potent that the initial shock to the nasal mucosa results in secondary engorgement, or “rebound” swelling.

ARAMINE appears to have no vasodilating component, and its vasoconstrictor action is not so intense or prolonged as to irritate or damage the sensitive nasal mucosa.

ARAMINE acts rapidly, but *gently*; it possesses a moderate duration of action. It has no apparent stimulant effect on the central nervous system, and does not appreciably interfere with normal ciliary activity.



The MUIT atomizer-dropper may be easily carried in the pocket or handbag, to be used inconspicuously, as an atomizer or dropper, at home or at work.

is Applied with Unique New Atomizer-Dropper



Aramine

BITARTRATE



ARAMINE is supplied as an isotonic solution of ARAMINE bitartrate, (0.25% ARAMINE) with a pH of 6, compatible with normal nasal physiology.

Combination packages contain 1 oz. ARAMINE with MUIT. Also, 1 oz. bottle with plastic dropper.

Sharp & Dohme, Philadelphia 1, Pa.

‘MUIT’ DELIVERS MEDICATION AS FINE,
PENETRATING MIST, OR AS INDIVIDUAL DROPS

Equipped with a specially designed plastic nozzle, the MUIT atomizer delivers ARAMINE Intranasal Decongestant as a fine, penetrating mist, or (when inverted) as drops. When used as an atomizer, MUIT assures diffusion of ARAMINE in nasal passageways.

When inverted, the MUIT may be used as a dropper for those occasions in which it is desirable to concentrate medication on the engorged epithelium of the turbinates to relieve obstruction of the nasal airways.

So the G.P. can do one of two things: He can stand on the steps of the hospital, musing complacently on his status as a great force in medicine, while the hospital door is closed in his face. Or he can join the A.A.G.P. and fight to hold the door open.

Lyon Steine, M.D., Secretary
General Practitioners Assn.
of Nassau County
Valley Stream, N.Y.

Uniformity in Licensing

Sms: As a graduate of a foreign medical school, I agree wholeheartedly with Dr. Peter Illberg's recently published letter in *Speaking Frankly*. Like him, I deplore the lack of standardization of state board exams. And I'm disturbed by the multitudinous and inconsistent regulations for both American and foreign doctors.

It's my understanding that under the British system admission to the Medical Register entitles the registrant to practice wherever the Union Jack flies (except for a few provinces in Canada). It should certainly be possible—with due regard to states' rights—for the A.M.A. and the boards of the various states to work out an equitable method of registration for this country.

Kenneth I. E. Macleod, M.D.
Ayer, Mass.

Blue Cross Abuses

Sms: Blue Cross spokesmen constantly complain that doctors abuse the service. But if Blue Cross sin-

cerely wants an end to such abuses, I suggest two simple solutions to the problem:

First, let the plans publicize the *limitations* of their policies as well as the benefits. The family doctor who is faced with a sick patient and a worried family should not have to explain why, in this case, Blue Cross won't pay for hospitalization. No wonder he sometimes decides to stretch a point.

Second, let Blue Cross refuse to pay up in a few of the most flagrant cases of abuse. I imagine there are plenty of abuses in my locale, but I've never heard of Blue Cross objections to a bill!

The most that any health plan should expect from the physician is a reasonable amount of cooperation. He isn't a policeman; any attempt to make him enforce rules that Blue Cross itself is unwilling to enforce must end in failure.

Joseph C. Humbert, M.D.
Stewartsville, N.J.

Gone Underground

Sms: A recent *Sidelight* suggests that the issue of compulsory health insurance is more than half dead. I wonder. Isn't it possible that the socialist apparatus for taking over medical control has merely gone underground for a while?

The advocates of compulsory health insurance have met unified resistance to any sudden over-all change in medical care plans; but I doubt whether they've given up the ghost. Instead, they'll try to accom-



you may choose specific therapy
from this complete iron line

Feosol* Hematonic—the *new*, five-factor blood-building preparation

'Feosol' Tablets—the standard iron therapy

'Feosol' Elixir—the outstanding liquid iron preparation

Feosol Plus*—the ideal iron-liver-vitamin formula

Feojectin*—the safe, rapid-action *intravenous* iron

The most *positive* treatments
for the most common deficiencies

Smith, Kline & French Laboratories, Philadelphia

★T.M. Reg. U.S. Pat. Off.

2 tsp. t.i.d.



the psychological value of a good tonic

The benefit of a good tonic is not entirely limited to its tone-restoring and appetite-stimulating effects.

Most physicians know how much the little ceremony of taking each pre-meal dose of 'Eskay's Neuro Phosphates' or 'Eskay's Theranates' can brighten "the endless, daily, dull routine" of the elderly patient's life.

And—of great importance—"his tonic" is an ever-present symbol of the reassuring and comforting fact that he is "in the care of his physician".

Smith, Kline & French Laboratories, Philadelphia

Eskay's Neuro Phosphates ★

a palatable, restorative tonic

Eskay's Theranates ★

the formula of famous 'Neuro Phosphates' plus Vitamin B₁

Prescribed so widely because they work so well



plish their ends by pushing through tiny bits of encroaching legislation. And these will eventually encompass all that the Wagner-Murray-Dingell bill proposed.

A. G. Blazey, M.D.
Washington, Ind.

Who Does Operations?

SIRS: Can you furnish any data on the percentage of operations done in this country by G.P.'s?

E. J. Joergenson, M.D.
Glendale, Calif.

According to one widely accepted estimate, G.P.'s perform about 50 per cent of surgical operations in the United States. But there is no factual support for the figure, so far as we know. The Commission on Financing of Hospital Care has come up with a different figure—for one state, at least. Its detailed study of medical care in North Carolina reveals that less than 40 per cent of surgery is done by G.P.'s.

Estate Planners

SIRS: MEDICAL ECONOMICS and the Journal A.M.A. have recently carried articles on estate planning. Ever since those in the latter publication appeared, self-styled "estate planners" have descended on me like a flock of vultures.

All of them follow the same annoying routine. They're not salesmen. They didn't come to sell me insurance. They have specialized training in scientific estate planning, just as I have specialized training in my own field. And they're so busy



The patient who insists on devouring his food in a hurry often pays the penalty of upset stomach for his speed with the knife and fork. BiSoDol, the dependable antacid, provides fast relief from stomach upset due to excess acidity by efficiently neutralizing the excess gastric juices that cause upset. And BiSoDol provides long-lasting relief, is pleasant tasting—well tolerated. Whenever your patients require really fast relief from acid indigestion, suggest BiSoDol Mints, Powder or *NEW* BiSoDol Chlorophyll Mints.

BiSoDol®
tablets or powder



WHITEHALL PHARMACAL COMPANY
22 East 40th Street, New York 16, N. Y.

they can accept only two or three more clients.

Luckily, I have known an insurance salesman—not an “estate expert”—for fifteen years. He doesn’t try to sell me something that I don’t want and can’t afford. He admits that too much insurance isn’t a good hedge against inflation.

Am I making a terrible mistake if I continue to deal with that man?

M.D., Colorado

V.A. Care

SIRS: In his “Memo” for September, 1952, the publisher of MEDICAL ECONOMICS states that “our editors naturally take great pains to get their facts right.” Does this apply to the editorial cartoon on page 68 of the same issue?

According to the cartoon, free medical care is “available indiscriminately to 18½ million veterans.” This seems to imply, without factual basis, that all veterans are entitled to Federal hospitalization.

Under the law, the Veterans Administration has the primary responsibility of caring for those with service-connected disabilities. After such veterans are considered, the V.A. may then provide hospitalization for non-service-connected cases if beds are available and if these patients say they can’t pay for private care.

And how many veterans are now taking advantage of such free hospitalization? Here are the facts:

At the end of July, 1952, there were 105,911 veteran patients in

Used by Doctors for Over 35 Years!

Kalak *allays nausea
of pregnancies*



NOT A LAXATIVE

Many women have passed through parturition with comfort in using **KALAK** to thwart the usual nausea and “morning sickness,” especially prevalent during the early months of pregnancy. Besides its refreshing effervescence, it gives the body increased basic salts necessary to maintain neutrality of body fluids.

Also, it furnishes calcium in its most readily absorbable form which is required to provide bone and other parts of the fetus. In this way there is less drainage of lime from the mother. Pregnancy involves a certain amount of flatulence and **KALAK** causes eructation and mobilization of gas in the intestines. Unlike fruit juices, there are no fermentable or gas-forming substances in **KALAK**.

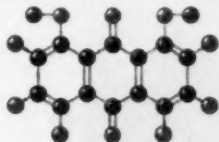
KALAK WATER CO. of NEW YORK, Inc.

90 West St., New York 6, N. Y.

DORBANE

TRADEMARK

[1, 8-DIHYDROXYANTHRAQUINONE SCHENLEY]



an effective, modern therapeutic agent chemically related to cascara, for precise, well-tolerated, individualized management of acute or chronic constipation

DORBANE*—a pure compound—exerts a mild yet dependable effect on the large bowel. Effective dosage can be determined individually with ease and accuracy. Abundant clinical evidence has shown DORBANE to be free from undesirable side-effects.

AVAILABLE as DORBANE Scored Tablets, bottles of 100, each containing 0.150 Gm. active ingredient; and DORBANE Confets* (orange-flavored wafers, like candy), tubes of 20, each containing 0.075 Gm.

ADMINISTERED one hour after evening meal (evacuation usually occurs the following morning). Dosage for adults— $\frac{1}{2}$ to 2 tablets or 1 to 4 Confets daily; for children— $\frac{1}{2}$ to 1 tablet or 1 to 2 Confets. Start with minimum dosage and adjust to individual response.

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LAWRENCBURG, INDIANA

schenley

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*Vaporizer for the
Highest Output of
Steam per hour*



**For Your Files: Facts About
The
DeVilbiss Vaporizer No. 149**

By all standards of judgment, the finest vaporizer you can recommend to your patients is the DeVilbiss No. 149. Of particular importance is the fact that the DeVilbiss No. 149 converts 8 to 10 ozs. of water into vapor each hour.

Has automatic safety shut-off. Operates 8 to 10 hours without refilling. Vaporizer bears the seal of the Underwriters' Laboratories and the Good Housekeeping Seal of Approval. Easy to care for and covered by complete service policy. You can recommend the DeVilbiss Vaporizer No. 149 to your patients with complete confidence. \$15.00. The DeVilbiss Company, Somerset, Pa., and Windsor, Ontario.

DEVILBISS

**ATOMIZERS • VAPORIZERS
NEBULIZERS**



"The Line the Physician Knows and Prescribes"

V.A. and non-V.A. hospitals. An additional 22,500 veterans were on the waiting list. At that time, there were more than 19 million veterans in the country.

This means that only five out of every thousand veterans were patients, and one other was seeking admission. Percentage-wise, that adds up to one half of one per cent of the veteran population. What's more, many of the veterans have service-connected disabilities, or are tuberculous, mentally ill, or long-term chronics. As a group, then, they couldn't be cared for except in V.A. hospitals, regardless of their ability to pay.

T. O. Kraabel, Director
Natl. Rehabilitation Commission
The American Legion
Washington, D.C.

The cartoon in question neither says nor implies that all veterans are entitled to Federal hospitalization. Nor does it maintain that they're all getting it.

There's ample evidence, however, that any veteran who needs hospitalization and who wants V.A. care can have it—without hindrance from Government officials, and without any particular strain on his morality. [See "Our 'Free-for-All' V.A. Hospitals," July 1952, MEDICAL ECONOMICS.]

We don't necessarily blame the veterans, the V.A., or the American Legion. But we do adhere to the belief that something is wrong with a system that permits no protection against such abuses.



Have you tried PENTIDS in the more common bacterial respiratory infections?

*"PENICILLIN . . . first line of defense against most common bacterial infections"**

Just 1 or 2 Pentids Tablets t.i.d. are particularly effective against the more common bacterial respiratory infections. . . convenient, easy-to-take . . . cause fewer side effects. . . and are less than 1/2 the cost of the newer antibiotics.

*Hear, A. D., Jr., Med. Clin. North Amer. 36:1607, Nov. 1952

SQUIBB

PENTIDS

500 mg. (100,000 UNIT) PENICILLIN G POTASSIUM TABLETS



Get the Story Quicker . . . More Clearly

MAY OPHTHALMOSCOPE

Daylight Blue Light and May prism design assure a brightly lighted field free from filament images and spots. Colors are natural. You can make diagnoses with greater speed and ease. Fingertip controlled lenses range from +20.00 to -25.00D with numbers magnified and illuminated for easy reading in the dark. Handle houses adjustable rheostat. In attractive, durable case.

HAND DIAGNOSTIC SET

Designed for maximum speed and ease of use. Includes May Ophthalmoscope and Arc-Vue Otoscope, battery handle and extra lamp, with 4 specula in durable carrying case.



BAUSCH & LOMB

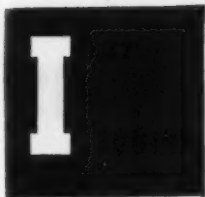
OPTICAL COMPANY



ROCHESTER 2, N. Y.

Hand Diagnostic

INSTRUMENTS



The TINY GIANT

Element of Biological Necessity

Organidin®

IODINE ORGANICALLY COMBINED

The unfolding secrets of metabolism reveal man's dependence upon IODINE as the "ELEMENT OF BIOLOGICAL NECESSITY."

IODINE poverty and mild hypothyroidism appear to be part of the aging process after the 40th year. The most prominent complaints of this age group are *chronic fatigue, poor memory, and sleeplessness.*

IODINE medication in these patients with beginning thyroid inadequacy may be of real benefit in restoring *mental alertness and physical vigor.*

Evidence is accumulating that mild iodine deficiency and hypothyroidism may produce cumulative harm in contributing to *hypercholesterolemia, myocardial damage and mental regression.* Judicious use of IODINE may well prove to be an important preventive and corrective measure after the 40th year.

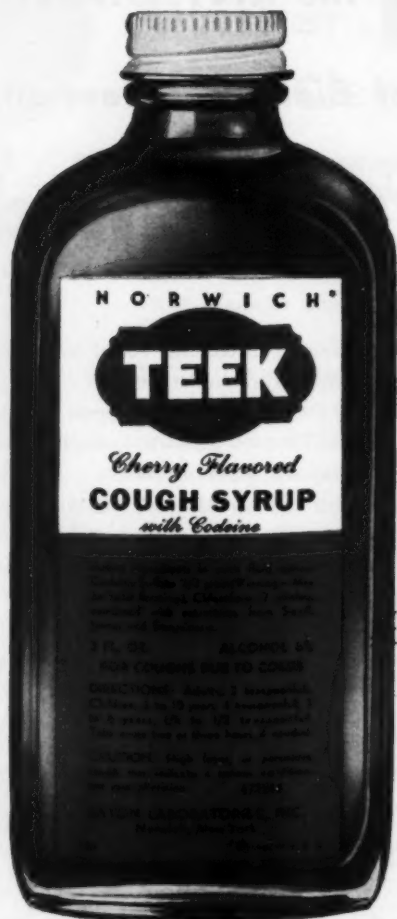
ORGANIDIN WAMPOLE is a unique, well-tolerated, standardized iodine preparation which is the result of original research in the laboratories of Henry K. Wampole & Co., Inc. Consistently satisfactory therapeutic results have established ORGANIDIN as the IODINE preparation of choice among the vast majority of physicians.

*Supplied: 30-cc. bottles with dropper.
Literature and sample on request.*

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INCORPORATED

Crampton, C. W., The Merck Report, 57:26 (1948)
Kimble, S. T., and Steigltz, E. J., Geriatric 7:20 (1952)

TEEK for coughs



Contains codeine $\frac{1}{2}$ grain per oz.; extractives of squill, ipecac and Sanguinaria; chloroform and alcohol.

Exempt narcotic—
prescription not
required.

provides:



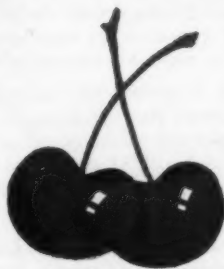
prompt cough relief



**effective expectorant
action**



**soothing, palatable
vehicle**



**Delicious
Cherry
Flavor**

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NORWICH, NEW YORK

524



Looking for natural B-complex in starting cereals?

*B-Complex for
your "normal"
little patients*

Medical opinion today generally accepts the premise that brewers' yeast is one of the finest sources of B-complex. Not only does brewers' yeast supply important amounts of the known B-vitamins . . . but it also makes available most of the "unknown" factors. Also of importance in infant-feeding is the fact that the good-quality proteins of brewers' yeast supplement the cereal protein.

Three of Gerber's Starting Cereals—Barley, Oatmeal, and Cereal Food (wheat) — are supplemented with brewers' yeast . . . in addition to iron and calcium.

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Unique among hypo-allergenic, one-grain cereals for babies . . . Gerber's Rice Cereal has as its source of natural B-complex rice polishings . . . second only to brewers' yeast in value of known and unknown B-vitamins. Gerber's Rice Cereal is enriched with iron and calcium.



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when
skin irritations
make
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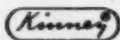
Soothes-Protects-Aids Healing



Contains benzethonium chloride and zinc oxide, effective skin antiseptics, in a bland lanolin absorption base. Allays burning and itching . . . softens and protects the skin . . . helps ward off secondary infection in prickly heat, chafing, diaper rash, "winter itch," etc.

SUPPLIED: In 2-oz. tubes.

AND FOR ADDED PROTECTION IN DIAPER RASH... **AMMORID** Diaper Rinse Contains methylbenzethonium chloride to prevent growth of organisms responsible for diaper rash.
SUPPLIED: In bottles of 240 Gm.



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CONSTIPATION
AND
HYPERACIDITY
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Phillips' Milk of Magnesia has been
generally accepted by the medical profession
as a standard therapeutic agent
for constipation and gastric hyperacidity*

As a laxative—Phillips' mild, yet thorough action is dependable for both adults and children.

As an Antacid—Phillips' affords fast, effective relief. Contains no carbonates, hence produces no discomforting flatulence.

DOSAGE:

Laxative: 2 to 4 tablespoonfuls.

Antacid: 1 to 4 teaspoonfuls, or
1 to 4 tablets.

Prepared only by THE CHAS. H. PHILLIPS CO. DIVISION • 1450 BROADWAY, NEW YORK 18, N. Y.
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Donnalate[®]

to relieve gastric
acidity.

to stabilize emotional
tension and anxiety.

to relieve smooth
muscle spasm.

Donnalate incorporates the pharmacological features of both *Bebalol* (for peptic ulcer) and *Donnatal* (for spasmodics). Each Donnalate Tablet contains 0.5 Gm. dihydroxy aluminum aminoacetate, 0.1 mg. phenobar-

bitol, 0.052 mg. hyoscyamine sulfate, 0.01 mg. atropine sulfate, and 0.003 mg. hyoscyne hydrobromide (the equivalent of one *Bebalol* tablet plus one-half of one *Donnatal* tablet).

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Comprehensive Therapy of the Anemias with

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MOL-IRON[®] E.M.F.

(ERYTHROCYTE
MATURING
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Because it is a potent source of essential erythrocyte maturing factors and also supplies the first-ranking* form of iron, Mol-Iron E.M.F. provides effective therapeutic control of all microcytic and macrocytic anemias amenable to oral therapy.

Potent in All Factors

Each Mol-Iron E.M.F. Capsule contains:

MOL-IRON.....198 mg.
(molybdenized ferrous sulfate)
Vitamin B₁₂ Activity Equivalent 10mcg.
(as in *Streptomyces fermentation extractives*)
Gastric Substance.....250 mg.
Desiccated Liver.....100 mg.
Folic Acid.....0.85 mg.
Ascorbic Acid.....50 mg.



To date 12 reports on Mol-Iron have appeared in medical literature; all point to the conclusion that Mol-Iron is more effective and better tolerated than unmodified ferrous sulfate and other iron salts.

Recommended therapeutic dose: 2 capsules t.i.d.—Bottles of 100 and 1000

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Sidelights

Negative Findings

"I paid the doctor \$35, and for what? For nothing!"

The man at the next table apparently didn't care who heard him. In angry tones, he was telling his coffee companion about the G.I. series he'd been put through. He'd found it both unpleasant and—since it hadn't shown a thing—unnecessary. "These doctors sure like to take your money for nothing at all," he concluded.

"Nothing at all." The phrase stuck in our mind even after the man had left. Here was a person who didn't know when he was well off. And why didn't he know? Because, from all the signs, his doctor hadn't taken time to explain that negative findings are usually *good* news.

It's *worth* taking the time, too, we reflected.

Just last month, Dr. Harold T. Golden of Herkimer, N.Y., published an estimate that 80 per cent of all diagnostic tests turn out negative. If a sizable number of people thus tested react the way our irate friend in the restaurant did, it can mean plenty of dissatisfied patients.

Yet it's no trick at all to satisfy them—as many a thoughtful M.D. discovered long ago. One G.P. we know, for example, makes a habit

of explaining all negative findings in some such terms as these:

"I have the results of your tests, Mr. Jones, and they're most encouraging. I know they weren't cheap or pleasant to take, but we've learned a lot from them. They tell us, for one thing, that there's nothing organically wrong; there's no sign of ulcers or of the more serious ailments you may have been concerned about. That news alone should help us make progress in clearing up your symptoms."

More talk like our colleague's would mean less talk like our coffee-table critic's.

Third-Party Papers

Everyone knows that a doctor's first loyalty is to his patients. Everyone, that is, except some insurance companies and government agencies.

Too often the paperwork required by these third parties puts the physician on the spot. They ask for confidential information about diagnosis and prognosis—yet, simultaneously, they ask that the form pass through the patient's hands.

Not long ago, a New Jersey physician found himself hung up on this dilemma. He was asked to fill out an insurance certificate for a woman

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DEPENDABLE
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ACTION

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Dihydrogen Citrate (FLINT)

PALATABLE SYRUP
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Write for your copy of
"The Present Status of Choline
Therapy in Liver Dysfunction"

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patient, then pass it along to her for signature. Trouble was, the woman had metastatic cancer involving numerous bones—and the doctor felt she'd lose her will to survive if she knew.

On the form the patient saw, therefore, the doctor masked the correct diagnosis by writing down "arthritis." Meanwhile, he notified the insurance company directly of the proper diagnosis.

Such improvisation is a fine thing. But the doctor, after all, shouldn't be forced to work out his own reporting methods.

Although some state disability boards have recently revised their forms to permit direct reporting of cancer and psychoses, a number of private insurance companies haven't yet followed suit. Until they do, many an M.D. will have to keep an eye peeled for third-party papers that threaten his first loyalty.

Compulsory Calls

Has the problem of providing around-the-clock medical service in emergencies been solved by doctors everywhere? You might think so, judging by the way some 600 emergency-call panels have been set up by medical societies all over the country in the last few years.

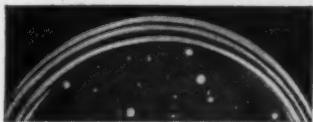
But doctors in each area would do well to ask themselves *how effective* their local panel really is. What's more, they'd do well to ask this question before the public asks it.

This warning stems from Maryland doctors, who know whereof

DIAL SOAP with Hexachlorophene

effects 95% reduction in skin bacteria

Photomicrographs show why



With ordinary soap. Even after thorough washing, thousands of active bacteria remain on the skin.



With Dial soap. Daily use of Dial with Hexachlorophene eliminates up to 95% of resident skin bacteria.

1. *Reduces chance of infection* following skin abrasions and scratches because Dial effectively reduces skin bacteria count.

3. *Protects infants' skin*, helps prevent impetigo, diaper and heat rash, raw buttocks; stops nursery odor of diapers, rubber pants.

2. *Stops perspiratory odor* by preventing bacterial decomposition of perspiration, known to be the chief cause of odor.

4. *Helps skin disorders* by destroying bacteria that often spread and aggravate pimples, surface blemishes.

You know, of course, the remarkable antiseptic qualities of Hexachlorophene soaps, as documented in recent literature. Dial was the first toilet soap to offer Hexachlorophene content to the public. You can safely recommend Dial. Under normal conditions it is non-toxic, non-irritating, non-sensitizing. Furthermore, Dial Soap is economical, and widely available to patients everywhere.



From the laboratories of
Armour and Company

Free to Doctors!

As the leading producer of such soaps, we offer you a "Summary of Literature on Hexachlorophene Soaps in the Surgical Scrub." Send for your free copy today.

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who have Seborrheic Dermatitis of the scalp . . . prescribe

this effective new product

Effective control of scaling . . . prompt relief of itching and burning . . . extreme simplicity of use . . . this is the story of SELSUN Sulfide Suspension, Abbott's new *prescription-only* product for the management of seborrheic dermatitis of the scalp. Clinical investigators who treated 400 patients^{1, 2, 3} found SELSUN effective in 92 to 95 percent of cases of mild seborrhea (common dandruff), and in 81 to 87 percent of all cases of seborrheic dermatitis.

SELSUN was successful in many cases that had failed to respond to other recognized methods of treatment. Optimum results were obtained in four to eight weeks, although itching and burning stopped after the second or third application in most cases. After the initial treatment period, a single application keeps the scalp free of scales for one to four weeks.

SELSUN is convenient to use, because it is simply applied while washing the hair and then rinsed out. It thus leaves the hair clean and odorless, and obviates the problem of stains on clothing and linens. Specific research on toxicity² shows there are no harmful effects from external use of SELSUN as recommended. Supplied by pharmacies in 4-fluidounce bottles, with tear-off labels. Dispensed only on a physician's prescription. **Abbott**

References:

1. Slinger, W. N., and Hubbard, D. M. (1951), Arch. Dermat. & Syph., 64:41, July.
2. Slepian, A. H. (1952), Ibid., 65:228, February.
3. Rich, D. M. (1951), Communication to Abbott Laboratories.



PRESCRIBE

SELSUN

TRADE MARK



SULFIDE *Suspension*

(SELENIUM SULFIDE, ABBOTT)

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doctor
THE SOAP
PREFERRED
IN SURGERY

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FOR FAST, SAFE
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Ask for FREE
Sample in
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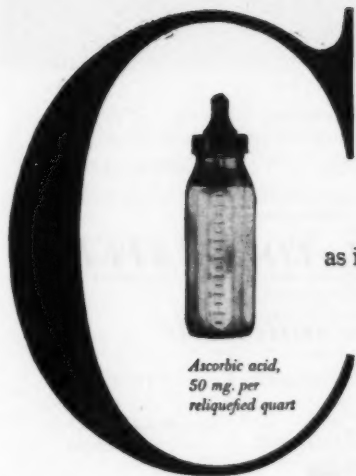
they speak. Last July, with appropriate fanfare, the Montgomery County Medical Society announced its new emergency-call service. Less than a month later, a local couple needed a doctor fast. Their little girl was suffocating with vomit in her windpipe. She choked to death before a doctor got there, and county police blamed the emergency-call bureau for the fatal delay.

Right then, the doctors decided that a volunteer panel wasn't effective enough. A few weeks later, they voted to reorganize their emergency-call bureau on a compulsory-service basis. Today all members of the society (including specialists) serve in rotation; they take twenty-four-hour shifts every three to six weeks.

This forthright action has been duplicated elsewhere. Around Binghamton, N.Y., for example, the emergency-call panel had dwindled to a mere dozen M.D.'s (and this for a county of 170,000 people). Acting *before* trouble struck, the Broome County Medical Society drafted every able-bodied private practitioner under 60 to take such calls in rotation.

Other societies have worked out variations of this idea. In some areas, emergency-call service is compulsory for all G.P.'s; in other areas, it's compulsory for all new medical society members. Details naturally depend on the society and its size.

But all such societies have one common point we commend to doctors everywhere. It's an awareness that ineffective emergency-call plans are worse than no plans at all.



constant
and
correct

as in **SIMILAC**

Similac provides, constantly and unvaryingly, 50 mg. of ascorbic acid per reliequied quart—an amount closely approximating the content of mother's milk—and in excess of recommended allowances. Similac thus assures adequate and continuous (through each feeding) Vitamin C intake now established as an effective safeguard against scorbutic and some anemic states during infancy.¹ The importance of an adequate intake is further reflected in the finding that Vitamin C is essential for utilization of the amino acid tyrosine, functioning probably as coenzyme.²

There is no closer equivalent to the milk of healthy, well-nourished mothers than Similac

providing; zero curd tension for easy digestion; fats chosen for maximum retention and high ratio of unsaturated and essential fatty acids; full balanced array of essential amino acids; folic acid and Vitamin B₁₂ (naturally occurring, in breast milk quantities); other vitamins in adequate amounts; minerals adjusted to favorable proportions.

**Supplied: Similac Powder, tins of 1 lb.;
Similac Liquid, tins of 13 fl. oz.**

M & R Laboratories
Columbus 16, Ohio

1. Tisdall, F. F., and Jolliffe, N., in *Clinical Nutrition*, New York, P. B. Hoeber, 1950, c. 23, p. 598. 2. Sealock, R. R., and Goodland, R. L.: *Science* 114:645 (Dec. 14) 1951.



the new

WELL-TOLERATED
wide-range antibiotic



Available in 100-mg. specially coated tablets in bottles of 36.

DOSAGE:

Adults—Total daily doses of 400 to 2,000 mg. are recommended, depending on the type and severity of the infection. Lobar pneumonia, bronchopneumonia, and some of the milder types of respiratory infections caused by organisms susceptible to 'Ilotycin' have consistently responded to doses of 100 mg. every four to six hours.

For other infections, larger doses of 300 to 500 mg. every six to eight hours should be employed.

Children—6 to 8 mg. per Kg. of body weight every six hours.

Therapy should be continued for at least forty-eight hours after the temperature has returned to normal and acute symptoms have subsided.

Lilly

THE ORIGINATOR OF ERYTHROMYCIN

'Ilotycin' is a powerful antibacterial of proved effectiveness* in the treatment of infections due to:

ORGANISMS	INFECTIONS
1. Staphylococci	Bacteremia, meningitis, pneumonia, osteomyelitis
2. Hemolytic streptococci	Cellulitis, erysipelas, peritonsillar abscess, pharyngitis, pneumonia, scarlet fever, septic sore throat, tonsillitis, wound infections
3. Pneumococci	Empyema, lobar pneumonia
4. Corynebacterium diphtheriae	Diphtheria carriers
5. Nonhemolytic streptococci	Some cases of endocarditis, genito-urinary tract infections

***References**

1. Heilman, F. R., Herrell, W. E., Wellman, W. E., and Geraci, J. E.: Some Laboratory and Clinical Observations on a New Antibiotic, Erythromycin ('Ilotycin'), Proc. Staff Meet., Mayo Clin., 27:285 (July 16), 1952. 2. Haight, T. H., and Finland, M.: Laboratory and Clinical Studies on Erythromycin, New England J. Med., 247:227 (August 14), 1952. 3. Smith, J. W., Dyke, R. W., and Griffith, R. S.: Erythromycin: Studies on Absorption Following Oral Administration and on Treatment of 33 Patients, to be published. 4. Spink, W. W.: Personal communications. 5. Romansky, M. J.: Personal communications.





**for the effective control
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Every day more physicians are discovering the early clinical benefits effected by the administration of **Piromen**, employed either as a specific, or concomitantly with other drugs.

Piromen is a biologically-active bacterial polysaccharide which produces a marked leucocytosis and a stimulation of the reticulo-endothelial system. It is nonprotein, nonantigenic, and may be employed safely within a wide range of dosage.

Piromen is prepared in stable colloidal dispersion for parenteral use. It is supplied in 10 cc. vials containing either 4 gamma (micrograms) per cc., or 10 gamma per cc.

For a comprehensive booklet detailing the use of this new therapeutic agent, merely write "**Piromen**" on your Rx and mail to—



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● **PROLONGED**

● **NOT FLEETING**

RELIEF FOR THE ARTHRITIC

ERTRON® was the first steroid complex advocated for use in the treatment of rheumatoid arthritis.



Despite the furore caused by the introduction of certain so-called 'miracle drugs' ERTRON still persists as a reliable standby in the practices of a large number of physicians.

With ERTRON, the systemic relief and objective improvement obtained is prolonged—continuous—not fleeting as is the case with some of the more recently described steroids and steroid stimulants.

ERTRON used by the physician affords a minimum of reaction. There is no observed interference with adrenal activity.

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1 choleric 2 digestant 3 laxative

specifically indicated in biliary constipation

Constipation is usually associated with biliary stasis and impaired digestion. Tablets of Caroid and Bile Salts with Phenolphthalein offer 3-way help in the reestablishment of normal function in these cases,

CHOLERETIC ACTION

- Stimulating bile flow for easier fat digestion

DIGESTANT ACTION

- The enzyme, "Caroid," promotes protein digestion

LAXATIVE ACTION

- With minimal laxative dosage

Supplied: bottles of 20, 50, 100, 500, and 1,000.

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Caroid® and Bile Salts
TABLETS

specifically indicated

in biliary dyspepsia
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TORYN^{*}

syrup • tablets

to replace codeine in

cough
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'Toryn' is a new, non-narcotic antitussive compound which
(1) reduces the sensitivity of the cough reflex and (2) relaxes
spastic bronchi to promote expulsion of dense secretions.

'Toryn', 10 mg., delivers a positive antitussive effect
equal to that of codeine, 20 mg.—but *unlike codeine...*

'Toryn' does not cause constipation.

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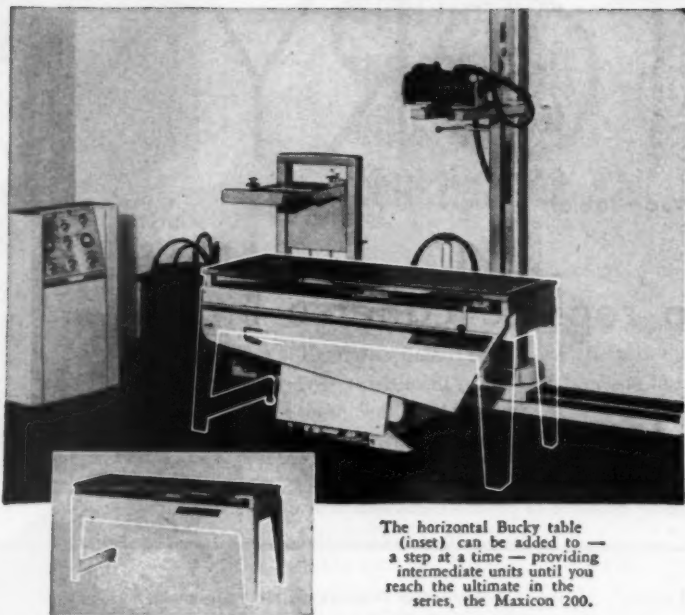
'Toryn' does not depress the patient.

'Toryn' has a remarkably low toxicity.

Available: Syrup: In 4 fl. oz. bottles
Tablets: Bottles of 25

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off. for caramiphen ethanedisulfonate, S.K.F.



The horizontal Bucky table (inset) can be added to — a step at a time — providing intermediate units until you reach the ultimate in the series, the Maxicon 200.

MAXICON 200 provides complete radiographic and fluoroscopic service

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Seconesin introduces a totally new idea in sedation...a safe, non-narcotic, rapid method to bring "a classical state of relaxation," a feeling of being pleasantly and comfortably at ease in tense, restless, anxious, wound-up patients.

each lime-colored, scored tablet combines:

MEPHENESIN 400 mg.

modern relaxant of choice • Council Accepted

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tried and true sedative • Council Accepted

Seconesin is safer because its euphoric influence is attained with a minimum of secobarbital...and because both its components are rapidly dissipated and eliminated. No fear of cumulation or "hangover."



Daytime relaxation with **Seconesin** is so calming that most patients *sleep well at night* without hypnotics.

Average dose: 1 Seconesin tablet every 4 hours; 1 or 2 on retiring but this is usually not necessary. Supplied on your Rx in bottles of 50, 100 and 500 tablets.

samples (perhaps for personal trial) and literature on request.

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Seconesin, trademark

Therapeutic Preparations for the Medical Profession

Which nutrient is the most important?

According to King¹ it is as foolish to stress the role of a single nutrient as it would be to stress the nutrition of a single part of the body.

All current nutritional research emphasizes that:

No particular vitamin or mineral is more important than another. • The quantitative requirements for nutrients are interdependent. • Imbalances in nutrition are to be avoided. • The optimum quantity of each nutrient is required daily for adequate nutrition.

To assure optimal intake of vitamins, minerals and trace elements, more and more physicians prescribe...

Vi terra

ALL IN ONE CAPSULE

1. King, C. G.: Trends in the Science of Food and Its Relation to Life and Health, Nutrition Reviews, 10:4, (Jan.) 1952.

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VITAMIN A.....	5,000 U.S.P. Units
VITAMIN D.....	500 U.S.P. Units
VITAMIN B ₁₂	1 mcg.
THIAMINE HYDROCHLORIDE.....	3 mg.
RIBOFLAVIN.....	3 mg.
PYRIDOXINE HYDROCHLORIDE.....	0.5 mg.
NIACINAMIDE.....	25 mg.
ASCORBIC ACID.....	50 mg.
CALCIUM PANTOTHENATE.....	5 mg.
MIXED TOCOPHEROLS (Type IV).....	5 mg.
CALCIUM.....	213 mg.
COBALT.....	0.1 mg.
COPPER.....	1 mg.
IODINE.....	0.15 mg.
IRON.....	10 mg.
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MAGNESIUM.....	6 mg.
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ZINC.....	1.2 mg.

...and superior stability

Superior stability . . . making refrigeration unnecessary, permitting safe autoclaving with the formula and assuring the vitamin potency you prescribe . . . is but one of the exceptional qualities of Poly-Vi-Sol.®

Superior flavor that assures patient acceptance . . . and superior dispersibility in formula, fruit juice or water . . . are among additional advantages provided by all three of Mead's water-soluble vitamin preparations.



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	Vitamin A	Vitamin D	Ascorbic Acid	Thiamine	Riboflavin	Niacinamide
POLY-VI-SOL Each 0.6 cc. supplies	5000 Units	1000 Units	50 mg.	1 mg.	0.8 mg.	5 mg.
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CE-VI-SOL Each 0.5 cc. supplies			50 mg.			

All vitamins are in synthetic (hypoallergenic) form.





puts a smile in the vitamin spoon



Each teaspoon of MULCIN supplies:

Vitamin A.....	3000 Units
Vitamin D.....	1000 Units
Ascorbic Acid.....	50 mg.
Thiamine.....	1 mg.
Riboflavin.....	1.2 mg.
Niacinamide.....	8 mg.

Available in 4 oz. and economical
16 oz. bottles.

Mulcin

It's the taste of Mulcin that all children like . . . the refreshing flavor of real orange. It's the ready acceptance of Mulcin that all mothers appreciate . . . no more need to coax or bribe even finicky children.

The light, smooth texture of this vitamin emulsion makes pouring easy. And Mulcin needs no refrigeration; even at room temperature its potency is assured.



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Editorial

Magnuson's Mixed Grill

● "What do you think of the Magnuson Report?" a doctor asked us the other day. And, for what it's worth, we told him:

"It's a compromise job—not as bad as feared, not as good as hoped. It doesn't really settle much of anything. As a result, it's not too likely to influence people one way or the other."

No capsule opinion can do full justice to the final report of the Truman-appointed Commission on Health Needs.* After all, the private testimony of nearly 500 medical and lay experts went into it. And ninety-one separate recommendations came out of it.

As a matter of fact, most of the recommendations are sound. From a doctor's viewpoint, we'd estimate that fifty-four of them are likely to prove wholly acceptable; twenty-seven perhaps acceptable with reservations or in part; and only ten probably not acceptable at all.

But statistics don't tell the whole story here, any more than they do in the fine art of cooking. We're reminded of the chef who does nicely

with the soup, salad, rolls, and French fries—and then messes up the steak. For the main course served up by the Magnuson Commission seems to us a dubious mixed grill.

It includes voluntary health insurance, compulsory health insurance, and seventeen kinds of expanded Federal aid. There's something in it for everyone—but too few hard decisions on what's good and what's bad.

Consider the commission's final verdict on national health insurance. Paul Magnuson once predicted that his group would "bury it for good"; and a majority of its members seemed predisposed that way. Yet look at the statement they finally signed:

"Unfortunately, such a violent controversy has arisen concerning this plan that it is very difficult to get an objective evaluation . . . It must continue to receive study and consideration as a possible solution to the problem."

Shades of Henry Clay! This prolongs a controversy which—as far as most people are concerned—died down some time ago. And it creates the suspicion that other commission proposals were fashioned like this one: out of compromise rather than deep-rooted conviction. [MORE→

*See "Highlights From the Magnuson Report" elsewhere in this issue. See also "What's in the Magnuson Report?" December MEDICAL ECONOMICS.

Consider, too, the recommendation for old folks' health insurance. In the passage quoted just previously, remember, the commission professed its inability to pass judgment on the Ewing scheme. Yet for people over 65, the commission blandly recommends an almost exact replica thereof.

Here's the precise wording:

"Funds collected through the [Social Security] mechanism [should] be utilized to purchase personal health service benefits on a prepayment basis for beneficiaries of that insurance program, under a plan which meets Federal standards..."

Many oldsters undoubtedly need health-cost help. But why assume that *all* of them do? Or that it must be *Federal* help? Or that they must be given health-service *benefits*

rather than the necessary cash?

This erratic treatment of major health issues is one reason that the Magnuson Report seems headed for the shelf. Here are two more reasons:

1. The new national Administration shows signs of leaning toward its *own* health studies and solutions, instead of relying on hand-me-downs from the previous Administration.

2. As long as military spending remains heavy, chances for big new Federal health programs remain light.

Thus, in purely practical terms, the Magnuson Report must be rated as relatively unimportant. There's good stuff in it but bad stuff too; and the combination won't strike many people as being easy to digest.

—H. SHERIDAN BAKETEL, M.D.

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What Will This Congress Do for You?

***Probably not much, says
this observer—but at least
it won't be hell-bent on
regimenting physicians***

● You can put 1953 down as a quiet year for medical legislation. All signs indicate that Congress will do less in the field than it has at any recent session. There are three reasons for this:

1. Both Congress and the Administration are hip-deep in issues nearing the crisis stage—like foreign policy and defense—and in issues that the new Administration has promised to grapple with early—such as revision of the Taft-Hartley Act. So there'll probably be little time for tackling other matters.

2. Many proposals of interest to doctors are now in the hopper, but with slim chance of further action. Why? Because they're disguised versions of bills that failed to pass during previous sessions. The present Congress, though Republican, is much like the last one. It's somewhat more sympathetic toward the doctor's point of view and somewhat more hostile toward Government interference in medical affairs. But

the attitude toward specific issues is basically unchanged.

3. There's an excellent reason for by-passing most proposals on medical matters in the mere fact of the change in Administration. After twenty years of Democratic management, Congress and the President want to take a good, hard look at Government agencies in the medical field, as they're now operating. In all likelihood, they'll study the problem thoroughly before tampering with existing arrangements.

Such an over-all study has already been recommended by Senator Taft, now Majority leader of the upper chamber. He'd like to see it conducted by a commission created by Congress, with members appointed by the President and by the House and Senate.

This study would not be a sequel to that made by the Magnuson Commission on the Health Needs of the Nation, which published its report last month. Instead, it would take a brand-new and broader view of all welfare problems, including Social Security. The projected body would probably re-examine the ground explored by the Magnuson Commission. But it wouldn't be like-

By Peter S. Nagan

ly to agree with all the Magnuson recommendations.

Taft's eagerness for a survey of this kind can be considered the first product of an evolution in his thinking on medical matters. In the past, the Ohioan has sponsored legislation for Federal grants to aid medical education and to help states provide medical care for the indigent. But he is known to be reconsidering his earlier position on such matters—especially since compromises and amendments have materially altered the substance of many proposals

that formerly claimed his support.

In all probability, he would expect the new commission's findings to help him formulate a revised viewpoint. And it goes without saying that any program he decides to back is an odds-on favorite to become law.

In the course of its survey, the commission would doubtless seek the views of all interested parties, including the medical profession. But it's unlikely that the study could be completed in time for action this year. Meanwhile, an informal mor-

These Doctors Now Help Make U.S. Laws



Ivor D. Fenton
R., Pa.



Walter H. Judd
R., Minn.

● There are five physicians in Congress this year—all of them in the House of Representatives. That's one less than the number who served in the old House.

Four of the five are veteran Congressmen. Ivor D. Fenton has put in fourteen years on Capitol Hill; Walter H. Judd

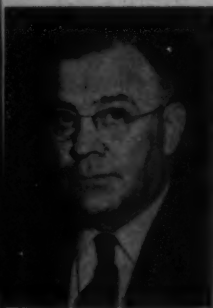
atorium on new proposals has been invoked by the Republican Congressional leadership.

Of course, this freeze won't bar legislation that's needed to keep already functioning programs going. But programs that are controversial, or would require increased Federal spending, will almost certainly be postponed.

Specifically, here's the outlook for major pieces of medical legislation—beginning with the measures that most doctors and their professional organizations want:

Chances seem poor for one of medicine's pet projects: a Federal Department of Health, headed by a Cabinet member. There are powerful interest groups with similar ambitions that oppose such eminence for medicine alone. So a broader Department of Health, Welfare, and Education is more likely to materialize.

Ex-President Truman, as everyone knows, wanted Congress to convert the Federal Security Agency into a Cabinet department. But the law-makers reject- [MORE ON 224]



Arthur L. Miller
R., Neb.



Thomas E. Morgan
D., Pa.



Will E. Neal
R., W.Va.

and Arthur L. Miller, ten years each; Thomas E. Morgan, eight years. The lone newcomer—Will E. Neal—is, oddly enough, the oldest member of the group; he's 77.

Two medical men who served in the Eighty-Second Congress didn't

make it this time. Dr. John T. Wood (R., Idaho) was defeated in his bid for a second term. And Dr. E. H. Hedrick (D., W.Va.), who'd held a seat for eight years, bowed out while trying unsuccessfully for the West Virginia gubernatorial nomination.

Storm Over Danbury

This conflict between hospital
lected medical standards. Mil
against the physicians ranging
whole story of what really hap

● Advance warnings of the storm gathering over Connecticut's Danbury Hospital went unheeded. Even when audible rumblings followed an exchange of unpleasanties between the board of managers and the medical staff, no one seemed to guess that worse was brewing.

That was in 1949. Ahead lay a year of mounting tension before the storm struck; then two years more of rancorous give and take before it reached its peak. By the time it finally subsided, it had generated more heat among Danbury's 30,000 people than almost any set-to since the American Revolution, when red-coats burned the town.

**This article is being published simultaneously in MEDICAL ECONOMICS and The Modern Hospital.*

"Danbury Crowns Them All" is the slogan of the busy little city in the Berkshire foothills. It manufactures more hats than any other city in the world. "And when it comes to hospital feuds," an officer of the Connecticut State Medical Society says, "it likewise caps them all."

How did Danbury's feud get so unexpectedly out of hand and run so long unchecked? How did it begin, and why did it snowball?

Those in the know say that the basic causes were typical, and that similar seeds of dissension exist in nearly all hospitals. What happened in Danbury should be taken to heart as an object lesson, they declare; for the Danbury experience emphasizes once more certain principles that are basic to sound hospital operation everywhere.

board and medical staff started innocently over the issue of negligence. It built up to a community-shaking climax, with the charges leveled from monopoly to manslaughter. Here, for the first time, is the story of what really happened at Danbury Hospital.

By Don Cameron

What those principles are and how they were underscored in Danbury follow:

Balance of Power

1. Hospital efficiency depends on a precise division of authority and responsibility among governing board, medical staff, and administrator. If this balance is upset—if responsibility is neglected or authority is exceeded in any corner of the triangle—trouble begins.

Trouble began in Danbury Hospital when the board of managers, a few years ago, took the staff to task for neglecting the interne program. Because of this apparent neglect, the A.M.A. Council on Medical Education and Hospitals had just dropped the hospital from its approved list.

The board also aired these complaints:

¶ Medical and surgical standards in the 170-bed hospital were not being maintained, especially in the matter of keeping records up to date.

¶ The staff appeared reluctant to discipline its members when rules were broken.

¶ The doctors sought to discourage competition, particularly in the surgical field, by a narrow policy of excluding newcomers.

The physicians admitted they deserved some of the criticism. But they resented the board's attitude. Some of its members, they said, had made it quite plain that they wanted the staff's neglected administrative powers placed in sterner hands.

"We didn't lay claim to a perfect record," says Dr. John D. Booth, a

Danbury surgeon, who was chief of staff at the time. "But we did feel that we were better able than anyone else to do what needed to be done."

In its subsequent handling of the interne program, the staff justified Booth's assertion. With internes hard to find, the managers had been ready to give up. But the doctors really went to work. Next time around, the A.M.A. inspectors approved the training program without qualification.

Unfortunately, that wasn't the whole story. Here's how Dr. Booth tells the rest of it:

"Unwritten records and lax discipline were head and tail of the same coin. It was up to me to recommend the temporary suspension of any staff member whose records hadn't been completed on schedule. But with the interne shortage making extra work for hard-driven doctors—and with close personal relationships to consider—that was one responsibility not easy to assume.

"So the policing job went to the hospital administrator, Anna M. Griffin, an R.N. She probably tried to handle it diplomatically; but there are times when a harassed M.D. won't take orders from an R.N.



Danbury Hospital was dropped from the A.C.S.-approved list while its staff and board managers wrangled. Now it's trying to make a comeback.

"It was an unhealthy situation, of course. And no one knew it better than the staff. But we had begun to make some headway toward straightening it out, with most of the doctors cooperating, when the board introduced its get-tough policy.

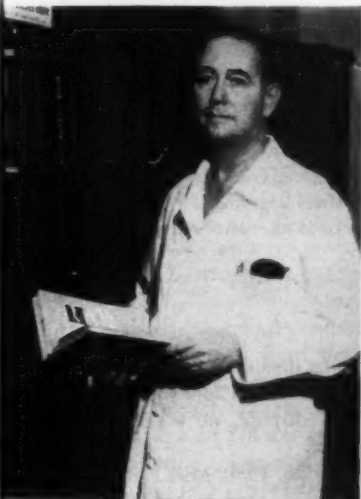
"Until then, staff-management relations had been good. It seemed reasonable to suppose that the bad feeling would pass as soon as the conditions that caused it were corrected. But it didn't work that way. A gulf had been opened, and it grew wider and deeper."

Another cause of friction lay in the managers' charge that the staff

doctors had attempted to exclude newcomers. A member of the board of trustees (which elects the managers as its executive body) explains the outcome in this way:

"The staff apparently didn't want full hospital privileges extended to a surgeon who had recently moved to town. Some members of the board of managers suggested that the local doctors were prejudiced because the new man was the only one among them with American Board certification. The managers appointed him to the staff, anyway."

This appointment—plus the fact that the doctor later became director



Drs. Booth (left) and Selleck were outspoken critics of the board. Their dismissal started the wave of public indignation that settled the feud.

A STATEMENT ABOUT THE DANBURY HOSPITAL

To All Persons in the Community
Served by the Hospital

The members of the Board and Staff of the Danbury Hospital are committed to the maintenance of the highest standards of medical and nursing care for the community.

1. The board must have the highest regard for the best interests of the community.

2. The board must have the highest regard for the best interests of the community.

3. The board must have the highest regard for the best interests of the community.

4. The board must have the highest regard for the best interests of the community.

5. The board must have the highest regard for the best interests of the community.

6. The board must have the highest regard for the best interests of the community.

The members of the Board and Staff of the Danbury Hospital are committed to the maintenance of the highest standards of medical and nursing care for the community.

Respectfully submitted, the Board and Staff of the Danbury Hospital.

November 15, 1951

Hospital and Hospital Staff

An Open Letter To The People of Danbury...

From
The Board of Directors
of the Danbury Hospital

The Board of Directors of the Danbury Hospital is pleased to announce the election of a new Board of Directors for the year 1952. The new Board is composed of the following members: [List of names and terms].

Hospital Board Comments On Staff Advertisement

The Board of Directors of the Danbury Hospital is pleased to announce the election of a new Board of Directors for the year 1952. The new Board is composed of the following members: [List of names and terms].

ACTION TAKEN

The Board of Directors of the Danbury Hospital is pleased to announce the election of a new Board of Directors for the year 1952. The new Board is composed of the following members: [List of names and terms].

The Board of Directors
Danbury Hospital

On the eve of the annual meeting for election of Danbury Hospital trustees in 1951, the squabble between staff and management overflowed into local newspaper ads. In full-page paid space (left) the staff protested a news release in which the board had blamed the doctors for lowering hospital standards. The board's reply (right) repeated its charges of staff laxity. And finally (center), the managers presented their arguments for employing an outside surgeon at \$16,000 a year to serve as executive chief of staff.

of surgery without the staff's recommendation—poured more sand into the already clashing gears.

None of these initial causes of the Danbury Hospital row was irredeemable. But with the balance of power shaken, the odds were against a lessening of tension.

2. Once dissension has begun to smolder, it can be inflamed by almost any dispute, no matter how extraneous.

On July 26, 1950, Miss Elizabeth M. Ayres, 74, died at home while under the care of Danbury Hospital's staff urologist, Donald F. Gib-

son. Dr. Gibson, who had shared the spinster's home was, by survivorship deed, sole heir to her \$72,750 estate.

A few hours after Miss Ayres' death, Dr. Booth, as Danbury Town Medical Examiner, emerged from a conference with state police officers to announce that he was "not satisfied" with the reports on her death. It was soon revealed that Dr. Gibson had arranged to send her body to Yale University Medical School for dissection; and to expedite this, he had allegedly prevailed upon Dr. Frank T. Genovese (who'd assisted him in treating Miss Ayres) to sign the death certificate while she was still alive.

The Gibson Case

The community knew that the hospital staff and management had been feuding for several months about something or other. Now, with two staff members the center of a seeming scandal, the feud became a matter of general interest. As far as the public was concerned, the firing of Gibson and Genovese was the immediate issue.

The board of managers, reproached for not taking action, let it be known that it was waiting for a recommendation from the staff. But spokesmen for the staff retorted that no formal charges had been brought against Gibson and Genovese and that no question of their staff duties was involved; so it was strictly a matter for the board to decide.

Says Dr. Ward B. DeKlyn, sec-

retary of the Danbury Medical Society, to which most of the staff members belong:

"It had long been obvious that the board of managers was determined to dominate the staff completely. Now, it appeared, the managers hoped to swing public opinion against all the doctors by raising a false issue."

Into the controversy at this stage stepped Walter Gordon Merritt, New York lawyer and member of an old New Fairfield family, whose father had been one of the incorporators of the hospital in 1907. Merritt made a point of sounding out both doctors and managers as to the advisability of keeping Dr. Gibson on the staff. Later, he published a twenty-page "white paper" on the hospital dispute.

Of a talk he'd had with Bernard J. Dolan, president of the hospital, Merritt wrote: "[Dolan said] that it was not only Dr. Gibson with whom management was concerned, but four others who should be removed from the staff . . . He stated that it was the intention of management to secure some outside doctor who, acting as director of surgery and chief of staff, would deal with these doctors."

Nearly a year after Miss Ayres' death, the coroner reportedly found reason to suppose that Gibson and Genovese might have precipitated it. So the board of managers promptly suspended both men from the hospital staff.

No formal charge was ever made

against Dr. Genovese. But the Connecticut Medical Examining Board later censured him for his handling of the death certificate, while absolving him of deleterious intent.

Dr. Gibson was acquitted in Fairfield County Court of manslaughter charges in December, 1951. The following May, the Medical Examining Board found him guilty on three charges of unprofessional conduct in the Ayres case. The board recommended that the State Health Department revoke his license to practice. Pending an appeal to the Connecticut Superior Court, Dr. Gibson still was practicing in Danbury as of December, 1952.

Neither doctor had been reappointed to the hospital staff or had sought reappointment.

The Gibson case, of course, had no close connection with the Danbury Hospital dispute. What it did was to help turn an essentially private quarrel into a public free-for-all. The bitterness it had aroused was still there when the final showdown came, late in 1952.

Bad Medicine

3. *A hospital can't be run solely by the rules for running a business. The "strong-man" tactics used sometimes in rehabilitating a company may backfire if applied to a hospital.*

Members of the Danbury Hospital's board of managers had been chosen (long before the fight started) for two qualities especially: executive talent and ability to raise money. The board's executive com-

mittee, which actively directed hospital affairs, was made up of men with considerable economic and political power in the community.

Heading the executive committee were the hospital officers: President Dolan, head of the Bethel National Bank and of the Danbury Industrial Corporation; Vice-President James D. Biggs, retired businessman; Secretary Walter J. Van Lenten, trust officer of the Danbury National Bank; and Treasurer Kenneth M. Hooper, president of the City National Bank and Trust Company of Danbury. Fellow members of the committee were James B. Lee and George A. McLachlan, presidents of two of Danbury's largest hat-manufacturing concerns.

Tough Tactics

As businessmen, the committee members felt called upon to use business methods in dealing with the dispute. Staff discipline had broken down, and a strong boss seemed to be the best means of restoring it. So, late in 1950, while the Gibson excitement was at its height, the managers quietly began negotiations with Dr. Francis M. Conway of Redding, a few miles away.

Dr. Conway, who also has a home and an office in New York City, was—and is—chairman of the medical practice committee of the New York State Workmen's Compensation Board at a salary of \$9,500 a year. In addition he is on the staffs of St. Vincent's and Gouverneur Hospitals, New York. [MORE ON 233]

Going to the Dogs ?



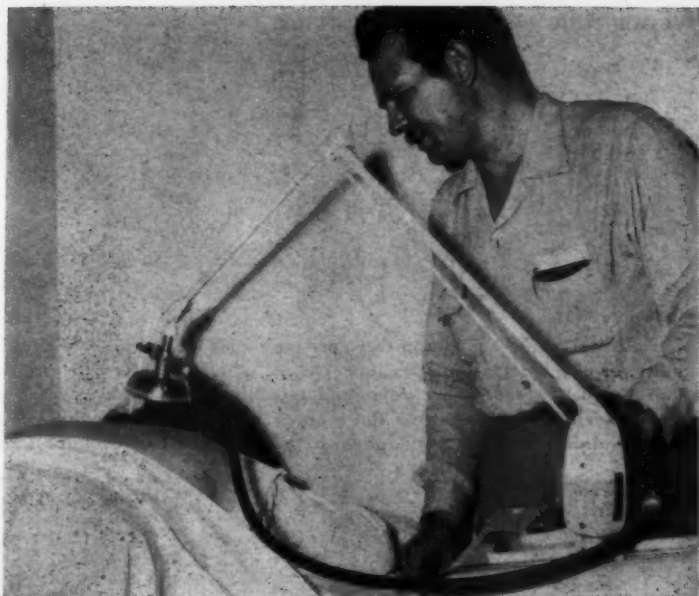
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Want a 'Clinical Associate'?

● A top-drawer lay assistant, combining both business experience and clinical training, would answer the prayer of many a busy M.D. But is the idea practical? Dr. Paul Williamson, director of the University of Tennessee's General Practice Office, thinks it may be. Why not, he asks, offer training courses for such all-around aides in the country's medical schools?

To test the idea, the University of Tennessee has hired a "clinical associate"—as Williamson calls him—to work in its general practice clinics. These pictures show some of the things he does.





[◀] Bill Wiles, the University of Tennessee's "clinical associate," applies his business experience to some medical bookkeeping. He's equally proficient in the use of medical equipment, like this diathermy machine [▲]. Patients call him "Mister," not "Doctor"; and he of course undertakes no tasks that require medical judgment. The well-rounded clinical associate, says Dr. Williamson, should be a former business executive in his thirties or early forties. Some years ago, the doctor hired such a man to help out in his country hospital. The experiment paid off; the new assistant, he says, became more useful in some ways than another M.D. could have been.

[MORE→]

Want a 'Clinical Associate'? (Cont.)

Most medical aides, Williamson feels, are somewhat limited in training and ability, or else tend to overspecialize. On the other hand, he believes, the clinical associate would have all-around capabilities and could relieve the busy doctor of many tasks that the average aide isn't quite up to. Wiles' varied training includes physiotherapy [►] and X-ray techniques [▼].





The University of Tennessee wants to evaluate the results achieved with Wiles before setting up a formal training course. Meanwhile, says Williamson, "we feel we're on the right track, and our plan may well succeed in bringing help to the doctor—especially to the overworked, small-town doctor."

END



Why Are Malpractice Rates Soaring?

The experience of one state provides straight answers to this and related questions

● The next time you renew your malpractice insurance policy, chances are you'll have to dig deeper to pay for it. In some areas, malpractice rates are ballooning to such dizzy heights that doctors may find their premiums doubled in a year or two.

It's not strange, then, that medical men are asking questions like these:

¶ *Why are malpractice rates going up?* Are more patients suing their doctors? Are the courts really awarding bigger judgments?

¶ *Is the patient or the doctor to blame?* Does the average doctor pay more because of claims caused by high-risk specialists, by big-city doctors, and by poorly-skilled practitioners?

¶ *What can be done to hold rates down?* Do preventive and public relations programs do any good? What can be done about the doctors who are poor risks?

¶ *What will happen if malpractice costs continue to soar?* Is there any danger, as sometimes rumored, that malpractice protection will become hard to buy?

As every doctor knows, factual answers to such questions are difficult to come by. For one thing, nationwide statistics aren't available. Nor are individual insurance companies eager to release their own figures. (Indeed, many companies don't have adequate statistics, because they write too few malpractice policies in any one area.)

Yet it's possible, by focusing on one part of the country, to get a fairly clear picture of the situation throughout the land. New York State, for example, provides as good a focusing point as you can find.

About 10 per cent of the nation's physicians practice there, and about two-thirds of these—15,000 medical men—are insured through the state society's group malpractice insurance plan. This is the largest number of doctors covered by a single insurance contract in any one area.

Since the plan is run by the doctors themselves, there's no tendency to keep the statistical results under wraps. What's more, the New York group plan probably has as complete a set of malpractice insurance records as is available anywhere.

New York has long been known as one of the worst malpractice sore-

By Roger Menges

spots in the nation. What's happening in New York, therefore, will not be reflected in the same degree elsewhere. But there's good reason to believe that the same trends are operating, even if to a lesser extent, in most other sections of the country.

What New York physicians have learned about malpractice insurance, therefore, may help clear up some of the unanswered questions that confront physicians everywhere.

More Doctors Sued

Why are malpractice rates going up? Few doctors have experienced such sharp increases in their malpractice premiums as have those insured through the New York group plan. In 1946, these physicians were paying a uniform rate of \$28 for policies with basic limits (\$5,000 maximum damages for any one act, \$15,000 for all acts committed during a policy year). Today, depending on specialty and location, they are paying from \$55 to \$156 for the same protection. That's two to five times as much.

Why such a whopping boost? Because the number of suits and claims has skyrocketed. During 1945, for example, there was one suit or claim to every seventy-one doctors in the plan. During 1951, there was one suit or claim to every thirty doctors.

Oddly enough, the size of settlements and judgments has had a much smaller effect on rates. It's true that New York courts have been getting more generous in individual cases. But it's also true that

some of the claims now being filed against New York doctors are less serious than those filed previously, and thus can be settled at a lower cost. So the cost of the *average* suit or claim has increased very little. It's still less than \$5,000.

Although recent cases in neighboring states have resulted in high verdicts (\$150,000 against the Federal Government for an Army doctor's alleged negligence; \$75,000 against a private M.D. for X-ray burns), the biggest sum paid out by the New York group plan has been \$45,000.

Nevertheless, the average doctor in the plan carries a policy with \$50,000/\$150,000 limits.

Doctors Aren't Guiltless

Who's to blame for high rates? Both patients and physicians, in the opinion of the seven doctors who make up the New York plan's malpractice insurance and defense board.

Patients are taking the attitude, says the board, that they can "sue doctors for every real or fancied result." This attitude has sprung up as a result of "a change in the moral climate of the country—the idea that you can get something for nothing."

Doctors must share the blame, according to the board, because a few of them are getting increasingly careless. "The more insurance protection they have," observes one board member, "the more chances they take."

Just a few notorious malpractice

cases apparently make the public claims-conscious. What's more, reports the board, such cases have influenced judges and juries to award damages not only for bona fide malpractice, but also for poor results.

Who Makes Mistakes?

Like many of their colleagues elsewhere, some New York State doctors think that they're paying for the mistakes of "the other fellow"—the specialist in a high-risk field; the big-city practitioner; the poorly-skilled man.

This probably was true a few years ago, when the group plan charged the same premium regardless of specialty or location. But now, rates have been set to reflect the hazards of particular types of doctors.

Surgeons (those whose medical practice is more than 5 per cent surgery) pay from one-third to two-thirds more for their insurance than do non-surgeons. Extra charges also apply to men doing X-ray therapy, electroshock therapy, and cosmetic plastic surgery.

Small-Town Costs Up

Doctors who practice in New York City (and in nearby Westchester and Nassau counties) are charged from 25 to 57 per cent more than doctors in the rest of the state. But, interestingly, malpractice costs in the upstate counties are increasing about three times as fast as those in the metropolitan area. If this trend continues, the rate differential

between urban and rural sections may eventually disappear.

The same trend may be underway throughout the country. If it is, doctors in lightly-populated areas will find their premiums gradually approaching those charged in densely-populated sections.

As for the contention that most losses are caused by poorly-skilled practitioners, H. F. Wanvig, indemnity representative of the New York plan, has this to say:

"Most of our biggest and spectacular losses are caused by some of the best doctors in the state, including chiefs of services at first-class hospitals. The only doctor who is free of a potential malpractice threat is the one who doesn't come in contact with the public."

How to Reduce Claims

What can be done to hold rates down? The malpractice board of the New York group plan is tackling this problem from two directions: (1) It is pushing a long-range program to improve doctor-patient relations; and (2) it is stepping up efforts to screen out of the plan those doctors who are poor risks.

Full-scale public relations programs are now operating full-tilt in three parts of the state. These programs include grievance committees, emergency call plans, and collection bureaus.

It's already obvious, says the malpractice board, that such efforts are helping to reduce the number of suits and claims. [MORE ON 195]

How to Deal With Problem Patients:

The Hellion

● What are the best ways to handle a child patient who is, to make no bones about it, a brat?

Through talks with a number of pediatricians and specialists in child behavior, I've found agreement on three basic techniques. They may not work all the time, but you should find them at least worth trying.

In your dealings with the more incorrigible small fry, here's the pitch:

Set a Standard

1. *Give him a standard to live up to.* "How quiet do you think you can be while I'm doing this?" the doctor asks. Any child is likely to answer, "Real quiet."

Then the doctor says, "I think you can be real quiet, too. But let's see." This is a particularly effective device because it gets the child to set a standard for himself.

Let Him Compete

2. *Make him feel he's competing with other children.* "I'm trying to see which of the boys who



comes to my office today acts most like a man," the doctor tells a rebellious little rascal. "The last boy I saw was pretty grown-up; but I think you can act even more like a man. Do you think you can?"

The child is likely to boast a little. Then the physician subtly points out that being like a man means being quiet and doing what the doctor says.

Keep Him Interested

3. *Explain your actions and make him wonder what's coming next.* The doctor tells the child what he's doing and what his instruments will discover. He makes it sound adventuresome and exciting. He lards his remarks with suspense, too—asking,

By David Rutherford

for example, "Well, what do you guess is going to happen now?"

He keeps talking even in the midst of a rumpus. ("The noisier they are," one physician says, "the more I'm inclined to whisper; for whispering gets more attention than yelling.")

The Wiseacre

A real equilibrium-shaker is the high-I.Q. brat. He's too bright to fall for the usual approaches; so he needs special handling.

A pediatrician I know gives this explanation of how he gets such little stinkers to cooperate:

"Usually I ask him what he plans to do after he leaves the office. He may say his mother has promised to take him to a movie. 'Well,' I reply, 'you aren't going to have much time for the movie if we don't get down to business here. If we keep on at the rate we're going, it'll take all afternoon; but if you do as I ask, you can be off to the movie in twenty minutes.' After that, the child is apt to be as good as Elsie Dinsmore.

"This strategy often works even if the youngster is simply going home to play. I ask him *what* he's going to play. I stimulate his anticipation. He's then eager to do what's necessary to get home as soon as possible."

Enlist the Parents

But what about the doctor who finds that no matter how hard he tries, he simply can't cope with certain little monsters? One physician

who has faced this problem says, "I make it completely clear to the parents that discipline remains *their* problem. When the going gets rough, I smile at the mother and say, 'I'm sure *you* can get him to do this, Mrs. Jones.'

"Or if the patient is extremely difficult, I may say, 'Well, Mrs. Jones, I don't seem to be getting anywhere with Johnny. Suppose I leave him with you for a while so you can talk to him. You can then tell the nurse when he's ready for me.' With that, I quietly leave the examining room; and in a surprisingly short time, Mrs. Jones usually brings Johnny around."

Let Him Yell?

There's one question that seems to bother many doctors: When the mother of an A-1 devil says, "Oh, go ahead and do it anyway, no matter how much he yells," what's the practitioner's best response?

Several experienced physicians have told me that in this event they simply take the mother's advice and do it. And in nine cases out of ten, they add, Junior doesn't make half the fuss expected. END

EDITORS' NOTE: *Have you found other, better ways to handle problem kids? Or have you ever had an instructive or amusing experience that may shed light on the subject? Send us your ideas or anecdotes; MEDICAL ECONOMICS will pay \$10 for each item that it accepts for publication.*



Your Economic Weather Vane

A report on the

Seventh MEDICAL ECONOMICS Survey

The facts in the following pages stem from the replies of about 5,000 practicing physicians to a questionnaire sent them by this magazine in April, 1952. These doctors constitute a representative cross-section of the profession; the information they supplied covers many phases of the economics of private medical practice in the U.S. In previous installments of survey data, we discussed such topics as the "average" physician, incomes, and expenses. This month we take up working hours, patient load, and time spent per patient. In the months ahead, we'll analyze such matters as collections and assistants. For a detailed account of how the Seventh MEDICAL ECONOMICS Survey was conducted, see page 95.

Physicians' Working Hours

Hours Devoted to Practice Weekly

All fields of practice	58
General practice	62
<i>Specialties:</i>	
Dermatology	49
Ear, nose, throat	52
Eye, ear, nose, throat	48
Internal medicine	56
Obstetrics/gynecology	55
Ophthalmology	46
Orthopedics	59
Pediatrics	60
Psychiatry/neuropsychiatry	51
Radiology/radiology	50
Surgery	54
Urology	54

Figures in this article are 1952 averages for independent physicians (those in private practice who derive more than half their net income from fees).

Survey Sidehikes

¶ The average doctor spends about as many hours at his practice now as he spent in 1948, but 10 per cent fewer hours than he spent at the height of World War II.

¶ As you'd expect, the more working-time a doctor puts in, the higher his probable income. For example: The M.D. who nets over \$30,000 devotes 35 per cent more time to medical practice than the one who nets under \$5,000.

¶ Yet the doctor who sees fifty or more patients a day devotes only half again as much time to his practice as the one who sees fewer than ten patients daily.

¶ The average small-town practice demands 21 per cent more of the physician's time than the average metropolitan practice.

¶ On the average, men doctors work 17 per cent more hours than women doctors. And independent practitioners work 12 per cent more hours than salaried. Both group and solo practitioners spend about the same amount of time at their practices. Nor is there much variation in the number of hours put in by physicians at the various levels of experience.



Time Spent per Patient

How Many Minutes the Patient Gets

All fields of practice	21
General practice	21
Specialties:	
Dermatology	18
Ear, nose, throat	21
Eye, ear, nose, throat	18
Internal medicine	26
Obstetrics/gynecology	22
Ophthalmology	20
Orthopedics	27
Psychiatry/neuropsychiatry	43
Radiology/radiology	18
Surgery	23
Urology	24

Figures in this article are 1982 averages for independent physicians (those in private practice who derive more than half their net income from fees).



Survey Sidelines

¶ The metropolitan M.D. spends 30 per cent more time per patient than does the small town doctor.

¶ The physician who employs one or more aides spends 40 per cent *less* time per patient than does the doctor without assistants.

¶ The medical man netting \$30,000 or more spends less than half as much time per patient as does the \$5,000-a-year man.

¶ Elsewhere, there's little variation in minutes spent per patient. Solo physicians, it's true, spend an average of 17 per cent more time per patient than do group physicians. But the figures for (1) young and old doctors, (2) independent and salaried doctors, and (3) men and women doctors are about the same in each of the three categories.

**Your Economic
Weather Vane**
(Cont.)

The Doctor's Patient Load

Number of Patients Seen Daily

	Office	Home	Hospital	Total
By all doctors	20	3	5	28
By general practitioners	23	4	4	31

Figures in this article are 1952 averages for independent physicians (those in private practice who derive more than half their net income from fees for service).





Number of Patients Seen Daily By Specialists

Dermatology	29
Ear, nose, throat	26
Eye, ear, nose, throat	28
Internal medicine	22
Obstetrics/gynecology	27
Ophthalmology	24
Orthopedics	24
Pediatrics	26
Psychiatry/neuropsychiatry	13
Röntgenology/radiology	30
Surgery	27
Urology	25

Your Economic Weather Vane

(Patient Load—Cont.)

Survey Sidelights



¶ The average independent physician sees 12 per cent more patients daily than he did in 1948. Relatively speaking, today's doctor also sees a higher percentage of patients in his office or hospital—and a lower percentage in their homes—than he used to.

¶ Less than half of 1 per cent of the doctors surveyed see 100 or more patients daily.

¶ Men physicians report higher patient loads than women; group doctors, higher loads than solo; and independent doctors, higher loads than salaried. But in none of these cases is the difference great.

¶ Doctors in towns of under 5,000 see 38 per cent more patients a day than do men in cities of 1,000,000 or more. In fact, the average small-town M.D. sees more office patients daily than the big-city physician sees in office, home, and hospital.

¶ Doctors with aides put in about the same number of working hours as those without aides. But their daily patient load is 60 per cent higher.

About the

Seventh MEDICAL ECONOMICS Survey:

● It was in 1929—a few months before the stock market crashed—that MEDICAL ECONOMICS published the results of its first survey of the economic status of U.S. physicians. More recent surveys, made every few years since then, have examined the doctor's practice through the lean days of the depression, the exhausting days of World War II, and the unsettled days of the post-war period.

The Seventh MEDICAL ECONOMICS Survey is the most comprehensive yet attempted. Like earlier ones, it was planned and prepared for publication by the editorial staff of this magazine, with the technical aid of consultants in research and statistics. The detailed statistical work was done by Columbia University's Bureau of Applied Social Research.

Who participated in the study? Copies of the questionnaire were sent by direct mail to a cross-section totaling about one-third of the country's active, private physicians. It was also published in the April, 1952 issue of the magazine—which

circulates, of course, to almost all private practitioners. Excluded from the survey group were doctors over 65, internes, residents, and medical men in full-time government service.

About 8,000 questionnaires were returned by the time statistical work was begun. Since this was a considerably larger sample than necessary for stable results, a free hand was used in discarding incomplete or inaccurate returns.

Other questionnaires were eliminated in order to make sure that the sample constituted a valid cross-section of doctors the country over. Actually, the unadjusted sample closely approximated the known distribution of physicians by three key variables: community size, geographic area, and years in practice. But it included a somewhat too great proportion of full specialists in relation to partial specialists and general practitioners. So, by means of a system of random discarding that preserved the close correlation with the other three variables, a number

of questionnaires from full specialists were removed.

The sample thus arrived at contained 5,009 questionnaires. Of these, 4,268 were returns from independent doctors (i.e., those who derive more than half their net income from non-salaried practice). Except where otherwise qualified, the survey breakdowns are based on the replies of these independent practitioners alone.

Results of the survey are being presented, several topics a month, in MEDICAL ECONOMICS. Breakdowns are made by such factors as years in practice, city size, geographic area, and specialty. The survey results are also being published in booklet form. END

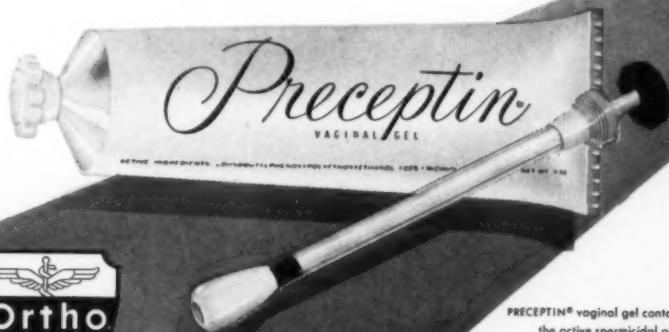
This is a condensation of a more detailed discussion of the purposes and methods of the Seventh MEDICAL ECONOMICS Survey. For the full text, see the October, 1952 issue.

© MEDICAL ECONOMICS



"Wilma, you haven't lived till you've had a date with a chiropractor."

clinically confirmed
esthetically acceptable
for simple
dependable contraception



PRECEPTIN® vaginal gel contains
the active spermicidal agents
p-Diisobutylphenoxypropylhexaethanol
and ricinoleic acid in a synthetic
base buffered at pH 4.5.

Ortho Pharmaceutical Corporation
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Ortho Kit



with the most widely prescribed jelly and cream

Ortho-Gynol[®] vaginal jelly: ricinoleic acid 0.75%, boric acid 3.0%, oxyquinoline sulphate 0.025%, p-Dicobutylphenoxypolyethoxyethanol 1.00%.

Ortho[®] Creme vaginal cream: ricinoleic acid 0.75%, boric acid 2.0%, sodium lauryl sulphate 0.28%.



Also available Ortho[®] White Kit with flat spring Ortho[®] White Diaphragm.

Your Tax Questions Answered

*Legal fees • Insurance premiums • Withholding for family
Value of clinic time • Domestic salaries • List of charities
Refund deductions • Moving expenses • Travel for health
Casualty losses • Army pay • Partners' contributions
Family mortgages • Title to building • Sale of practice
Hospital contribution • Apportioning income • License fees*

Legal Fees

Can I, for Federal income tax purposes, deduct legal fees I incurred in defending myself against a malpractice suit? I did not have malpractice insurance.

Yes. Legal fees in civil suits arising from professional activities are deductible. This is true whether the action is won or lost. But personal legal expenses—as for divorce proceedings or will-making—aren't deductible.

Insurance Premiums

Which of my insurance premiums are deductible?

Premiums on fire, theft, liability or any other insurance in connection with your practice. You may *not* deduct premiums for insurance covering your life, personal property, or personal liability. Cost of, say, fire protection for a home-office may be

deducted in part, depending on the extent to which the house is used for professional purposes. If, for example, you pay \$60 a year for fire insurance and your office takes four rooms of your ten-room house, you can deduct four-tenths of your premium—or \$24. If you pay the premium for three years in advance, to get a discount, you can deduct only one-third of the amount each year.

Withholding for Family

My daughter works as my secretary. Must I withhold income taxes on her wages? And must I withhold Social Security taxes as well?

Yes. You must withhold these taxes, just as you would for any non-related employee—with one exception: If your daughter is under 21, you must withhold *only* income tax.

By John C. Post

a 3-way attack on intranasal infection

'Drilitol' provides

1. double antibiotic action

'Drilitol' contains 2 antibiotics—anti-gram-positive gramicidin and anti-gram-negative polymyxin—to attack bacterial infection.

2. decongestive action

'Drilitol' contains the vasoconstrictor—Paredrine† Hydrobromide—to relieve intranasal congestion.

3. anti-allergic action

'Drilitol' contains the antihistaminic—thenylpyramine hydrochloride—to counteract local allergic manifestations.

'Drilitol' is indicated for the treatment of common upper respiratory tract disorders such as: rhinitis, nasopharyngitis, bacterial colds, sinusitis, coryza and allergic rhinitis.

Drilitol*

antibiotic, decongestive, anti-allergic

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off.

†T.M. Reg. U.S. Pat. Off. for hydroxyamphetamine hydrobromide, S.K.F.

in prescribing,
be sure to specify:



'Drilitol Spraypak'

Rx

*Drilitol Spraypak
Spray 3 or 4 times in
each nostril every 3 hours*

OR



'Drilitol' Solution

Rx

*Drilitol Solution
1 dropperful in each nostril
4 or 5 times a day*

es. According to the law, wage and salary payments made to any of your children under 21 (or to your spouse or parent) are exempt from Social Security taxes.

Value of Clinic Time

I serve several hours each week at free clinics. Can I deduct the value of my time, as a charitable contribution?

No. Charitable contributions must take the form of cash or property in order to be deductible. You may deduct the gas and oil consumed in traveling to and from a clinic; but you'll probably want to handle these as professional deductions, since charitable deductions are limited to 20 per cent of your adjusted gross income.

Domestic Salaries

I am a widower and employ a housekeeper to look after my children while I make calls. Can I deduct the housekeeper's salary as a professional expense?

No. This is considered a domestic expense. But if, in addition to caring for your children, the housekeeper also cleans your office, you can deduct part of her wages (just how much is determined by the proportion of her time spent in the office).

List of Charities

How can I be sure that the organizations I contribute to are considered charitable by the Bureau of Internal Revenue?

The bureau regards contributions as deductible when made to non-profit American organizations operated exclusively for charitable, religious, educational, literary, or scientific purposes. You can get a list of such outfits by writing the Superintendent of Documents, Government Printing Office, Washington 25, D.C. Ask for "Cumulative List of Organizations, contributions to which are deductible under Section 23(o) and 23(q) of the Internal Revenue Code." Price: \$1.25.

Refund Deductions

I've just discovered that I overlooked some professional deductions in figuring my 1951 tax. Can I deduct the refund I'm entitled to from this year's tax, and on this year's return?

No. You must fill out and file a separate refund application on Form 843.

Moving Expenses

I moved my home-office from one part of town to another last year. Can I deduct all the moving expenses?

No. You may not deduct the cost attributable to moving your home. The cost attributable to moving the office, however, can be deducted. You might allocate the expense according to the proportion of rooms used for your practice, on the assumption that the rooms contain roughly equal amounts of your possessions. If, for instance, your moving bill came to \$200 and your office occupies three of your eight rooms,

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To UNTANGLE

that

bundle

of nerves

BĒPLETE—for its tranquilizing effect on your tense, overemotional, anorectic patient. The **BĒPLETE** formula is a judicious combination of low dosage sedation and high dosage of vitamin B factors, including therapeutic quantities of vitamin B₁₂.

Bēplete®

Vitamins B Complex with Phenobarbital

... highly palatable Elixir, and Tablets. Also available, **BĒPLETE** with **BELLADONNA** for combined antispasmodic-sedative action; Elixir or Capsule form.



Philadelphia 2, Pa.

← Dissection of nervous system by R.B. Weaver, A.M., M.D., Sc.D., late Professor of Anatomy, Hahnemann Medical College and Hospital. Courtesy of Hahnemann Medical College Museum.



Bacitracin and tyrothricin, as combined in TRACINETS, are many times more effective in controlling certain infectious organisms in vitro than either antibiotic alone.

Antibiotic synergism explains
better response obtained in
throat infections with



TRACINETS provide local anesthetic action, to give prompt symptomatic relief in both infectious and non-specific sore throat. Each troche contains bacitracin 50 units, tyrothricin 1 mg. and benzocaine 5 mg.

Tracinetts®

BACITRACIN-TYROTHRIN TROCHES

Which also contain a
local anesthetic for
prompt relief of symptoms

SUPPLIED IN PLASTIC VIALS OF 12 TROCHES

Sharp & Dohme

Philadelphia 1, Pa.



TRACINETS may be employed to protect against sore throat in the early stages of a cold without danger of sensitizing the patient to antibiotics usually administered systemically.

the portion deductible as a professional expense would be \$75.

Travel for Health

I had to spend three months in Arizona for my asthma last year. Can I deduct the travel and hotel expenses I incurred?

Yes—if you can show that you went solely for the relief obtainable locally, and on the advice of another physician. But the burden of proof is on you. If the trip was designed partly as a vacation (even if ordered by a doctor), the travel deduction won't be allowed. Of course, your medical expenses would still be deductible within the usual limits.

Casualty Losses

In 1952, my wife lost an uninsured bracelet worth \$1,500. Can I deduct this amount as a casualty loss?

That depends on whether you can show that the bracelet is missing as the result of a casualty. If there's a possibility that it's merely misplaced, no deduction will be permitted. To be deductible, a casualty loss must be provable—as in the case of fire, storm damage, an accident, or burglary—and not caused by sheer carelessness.

Army Pay

Do I have to pay tax on the Army pay and allowances I received while in service last year?

You're required to file a return on March 15 (June 15, if stationed outside the U.S.), covering pay, allowances for transportation of de-

pendents, and outside civilian income. But allowances for quarters, subsistence, and uniforms, as well as Government allotments, are non-taxable. Also, the first \$200 of an officer's monthly pay in a combat area (like Korea) is non-taxable.

Partners' Contributions

I am a member of a medical partnership. Can my partners and I deduct charitable contributions from partnership income?

No. Your share of charitable contributions made by the partnership should be deducted on your individual tax return.

Family Mortgages

I meet the mortgage payments on my parents' home, though I don't own it. Can I deduct the interest on these payments from my taxable income?

No. You may not deduct payments on the obligations of others if you have no legal liability. Even if your parents are your dependents for tax purposes, the interest you pay on their mortgage isn't deductible; it's considered a gift.

Title to Building

I plan to buy the building I've been using as an office. Would I save taxes by putting title in both my name and my wife's?

No. Assuming you file a joint return, your wife already has, for tax purposes, a partnership interest in all your income. Besides, joint tenancy might make you liable to a big



1. Patient with idiopathic scoliosis.



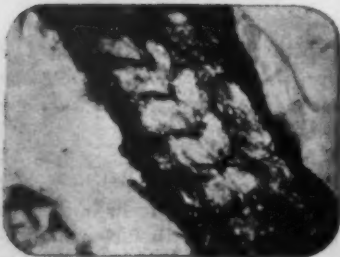
2. Surgeon beginning the operation.

Record it...

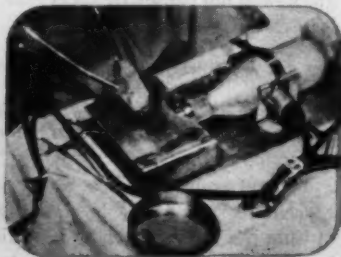
with motion, in black and white or color

BECAUSE hearing about it, or reading about it, lacks the impact of seeing it, motion pictures play an increasingly important role in teaching. Furthermore, a

motion-picture camera can capture a surgical technic completely . . . record every detail accurately—objectively—for showing days, weeks, years later.



3. Spine prepared for fusion.



4. Assistant preparing bone chips.



5. Placing bone chips along spine.



6. Appearance before closure.

From the "Bone Bank" film, prepared by the Hospital for Special Surgery.

Record it... with the Cine-Kodak Special II Camera

ACTUALLY the world's most versatile 16mm. motion-picture camera, it is the first choice of medical men everywhere. Improved two-lens turret accepts any combination of Kodak Cine Lenses. Through-the-lens focus-

ing and sighting for exact field coverage. Special controls for special effects. List price includes Federal Tax and is subject to change without notice—\$956.20, equipped with f/1.9 "Ektar" lens.

For further information, see your photographic dealer or write for booklet C1-35.

EASTMAN KODAK COMPANY
Medical Division, Rochester 4, N. Y.



Complete line of Kodak Photographic Products for the Medical Profession includes: cameras and projectors—still- and motion-picture; film—full-color and black-and-white (including infrared); papers; processing chemicals; microfilming equipment and microfilm.

*Serving medical progress
through Photography
and Radiography*

Kodak
TRADE-MARK

gift tax on half your investment. The reason: You would, in effect, be giving half the building to your wife.

Sale of Practice

I'm thinking of selling my practice. Will I have to pay regular income taxes on the proceeds, or can I treat them as a capital gain?

A doctor's practice is considered a capital asset; and if you've had the practice for longer than six months, you can treat the proceeds of its sale as a long-term capital gain.

Hospital Contribution

Doctors in my town have been asked to contribute heavily to a hospital building fund, to set an example for the rest of the community. Since I'll benefit from the new facilities, can I deduct my donation as a professional expense—not as a contribution?

The bureau might accept this as a



**"You don't bandage like Dr. White.
Dr. White uses wider gauze.
Dr. White . . ."**

professional deduction—especially if the amount of the contribution were far out of line with that made by others. But be ready to back up your reasoning with proof of benefits.

Apportioning Income

A patient paid me last year for treatment I had rendered over a four-year period. This put a bulge in my 1952 income. Is there any way I can spread the tax load over the four-year period?

Yes. You can apportion the lumped income, month by month, over the period during which your services were rendered. Then add each year's fraction to your total income for that year and recompute—at the then prevailing rate—the tax you should have paid. You owe, for each year, the difference between this figure and what you actually did pay. And you can pay the difference with this year's tax. To be eligible for such recomputation, however, the services must have been rendered over a period of thirty-six months or longer. And at least 80 per cent of the total payment must have been received in a single year—in your case, 1952.

License Fees

I paid a fee to take my obstetrical board examination. Is this fee deductible?

No. The tax laws don't permit deduction of expenses of medical education or certification. But you may deduct your physician's annual registration fee.

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SULFACETAMIDE

SULFADIAZINE

SULFAMERAZINE

the "extra advantage"
in this triple sulfonamide is
sulfacetamide

TRICOMBISUL® (acet-dia-mer-sulfonamides-Schering) provides not only
sulfadiazine and sulfamerazine — standard components
of almost all triple sulfonamide mixtures — but also sulfacetamide.

Sulfacetamide brings to the combination extremely high solubility, high
bacteriostatic activity, and greater safety for the urinary tract.

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TRICOMBISUL



Now — an American
plaster bandage
that equals the
world's finest
...and costs less

*New OSTIC has the creamy "feel" and workability
you expect only in the higher-priced bandages*

New OSTIC (Code 23) has been developed to give you that superior "feel" as you work it in your hands—but without sacrifice of fast wet-out, cast strength and proper setting qualities.

The new OSTIC Plaster Bandage goes on smoothly, feels like moist velvet in your hands, sculpts effortlessly and packs solidly—with no sensation of grittiness. A real pleasure to work with.

Try new OSTIC today. Let your own hands tell you its advantages. Your choice of fast or extra-fast-setting types—at no increase in established OSTIC prices.

Curity
THE WAY TO FAST SET
OSTIC® **NEW** **CODE** **23** **PLASTER**
BANDAGE

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DID YOU KNOW?

Curity WEBRIL® is the new absorbent cast padding that maintains normal skin condition



Unlike the conventional non-absorbable cast padding materials, *Curity Webril* bandages are extremely absorbent. *They absorb perspiration and skin exudate.* Thus, a Webril bandage not only protects against chafing by keeping the skin dry, it promotes better skin condition throughout the period of immobilization. And—Webril is easy to apply because it is conformable and sticks to itself—needs no taping. For patient comfort and for quick easy application, use *Curity Webril* bandages.

Do Doctors Want Social Security?

Most private M.D.'s don't, according to results of a survey by this magazine

● Should Social Security coverage be extended to private physicians? That's been a pertinent question since 1951, when most other self-employed persons came under the system. The question was included, therefore, in the Seventh MEDICAL ECONOMICS Survey form, filled out by some 5,000 M.D.'s in early 1952.* Here's an analysis of the response:

Fifty-five per cent of the independent doctors (i.e., those who derive more than half their net income from fees for service) oppose Social Security coverage for private M.D.'s; the remaining 45 per cent favor it. But among salaried doctors (those getting less than half their net income from fees) it's a different story: Sixty per cent think that Social Security *should* be extended to physicians in private practice.

Opposition to Social Security coverage is strongest in the small towns, where 72 per cent of the independent doctors apparently don't want it. In the big cities, however, 68 per cent of them say they're for it.

Women M.D.'s—who perhaps tend to let husbands do the worrying—are more opposed to coverage than are men. Sixty-four per cent of the independent women physicians say “No,” as against 55 per cent of the men.

You might expect that the more money a doctor made, the less likely he'd be to want Social Security coverage. The survey findings bear this out—but only slightly.

For example, the average net income of physicians who oppose Social Security coverage is \$15,998; the average net of those who favor it is \$14,546—not a great deal less. About 54 per cent of the doctors netting around \$5,000 oppose coverage, while an only slightly higher percentage (57) of those netting around \$30,000 are against it.

In all, income seems to be a negligible factor in determining how forcefully a man rejects the promise of a Government pension check. If it were important, you'd expect opposition to Social Security to be stronger among specialists than among general practitioners. But quite the reverse is true: Although only 51 per cent of full specialists are against the idea, 59 per cent of G.P.'s oppose it.

END

*For details on how the survey was made, see page 95.

By Wallace Crotzman

**Should Social Security Coverage
Be Extended to Private Physicians?**

*Here's how independent
medical men reply:*

Those in practice	Yes	No
Under 10 years	42%	58%
10-19 years	45	55
20-19 years	47	53
30 years or more	52	48

Those specializing in	Yes	No
Dermatology	52%	48%
EENT	32	68
ENT	44	56
Internal medicine	52	48
Obstetrics/gynecology	50	50
Ophthalmology	44	56
Orthopedics	33	67
Pediatrics	49	51
Psychiatry/neuropsychiatry	72	28
Radiology/roentgenology	43	57
Surgery	43	57
Urology	45	55
All specialties	49	51



IN GASTRON

Vagus
nerve

Preganglionic
neurone

Postganglionic
neurone

Sacral cord

Pelvic parasympathetic nerves

IN BRONCHIAL ASTHMA
GASTROINTESTINAL SPASM...

PARASYMPATHOLYTIC...

NOT *parasympathomimetic*

Parasympatholytic (as well as spasmolytic) in all therapeutic dosages, homatropine methylbromide affords dependable relief of gastrointestinal spasm. It is thus superior to many agents which are actually parasympathomimetic in customary dosages and parasympatholytic only in high dosages attended by disturbing side effects.

In Lusyn the antispasmodic efficacy of homatropine methylbromide is reinforced by phenobarbital to allay emotional tension. Lusyn also provides the antacid-adsorbent efficiency of Alukalin.

For intestinal spasm, biliary spasm, pylorospasm, cardiospasm and irritable colon.

MALTBIE LABORATORIES, INC., NEWARK 1, N. J.

LUSYN
(NEW FORMULA)

Each tablet contains:

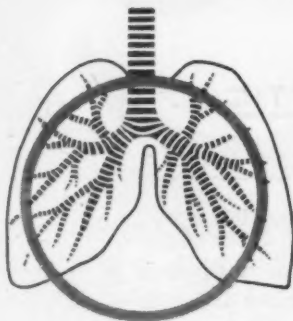
Homatropine methylbromide .5 mg. ($\frac{1}{12}$ gr.)
(increased from 2.5 mg.)
Alukalin (activated kaolin)....300 mg. (5 gr.)
Phenobarbital15 mg. ($\frac{1}{4}$ gr.)
(increased from 8 mg.)

Supplied: Bottles of 100, 500
and 1000 tablets.



In Bronchial Asthma

—an Effective Treatment



HP* ACTHAR Gel

(IN GELATIN)

Administered as Easily as Insulin:

Subcutaneously or intramuscularly with a minimum of discomfort.

Fewer Injections:

One to two doses per week in many cases.

Rapid Response, Prolonged Effect:

Combines the two-fold advantage of sustained action over prolonged periods of time with the quick response of lyophilized ACTHAR.

Much Lower Cost:

Recent significant reduction in price, and reduced frequency of injections, have increased the economy of ACTH treatment.

ACTH continues to be foremost in the treatment and management of intractable bronchial asthma. ACTH has been dramatic in relieving acute paroxysms of bronchial asthma; periods of complete freedom lasting for several weeks or months have been induced by a single course of ACTH therapy.^{1,2}

In 5 patients with chronic intractable asthma treated with ACTH or cortisone, incapacitating attacks were avoided and an asymptomatic state was restored. ACTH seemed to bring about more uniform results than cortisone.³ "A long-acting preparation of ACTH in gelatin gave the best results and required the smallest dosage."⁴

HP*ACTHAR Gel, the new repository ACTH, provides complete convenience and ease of administration in short-term treatment of bronchial asthma.

- (1) Bordley, J. E., et al.: Bull. Johns Hopkins Hosp. 85: 396, 1949; (2) Rose, B., et al.: Canad. M. A. J. 62: 6, 1950; (3) Randolph, T. G., and Rollins, J. P.: In Proceedings of First Clinical ACTH Conference, edited by J. R. Mote. Philadelphia, The Blakiston Co., 1950, p. 479; (4) McCombs, R. P., et al.: Bull. New England M. Center 12: 187, 1950; (5) Baldwin, H. S., and DeGara, P. F.: J. Allergy 23: 15, 1952; (6) McCombs, R. P.: New England J. Med. 247: 1, 1952.

*Highly Purified. ACTHAR® is the Armour Laboratories Brand of Adrenocorticotrophic Hormone—ACTH (Corticotropin)



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PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH

It's usually legal but not always safe:

The Telephoned Prescription

• Telephoning prescriptions saves time, all right. But it also entails risk. Generally, if the M.D. thinks of it, the patient can be told instead to stop at the office for a written Rx before he goes to the drugstore. Provided no additional fee is charged for this stop-in, there can usually be no valid objection on public relations grounds. And from the doctor's angle, having the patient (or a relative) pick up the written prescription saves time, trouble, and lawsuits.

Yet sometimes there seems to be no practical alternative to phoning the prescription to the pharmacist. And the law itself recognizes this.

The Durham-Humphrey Act (Public Law 215, Eighty-Second Congress) specifically permits the pharmacist to fill telephoned prescriptions for drugs that cannot be dispensed without a prescription*. The same law requires prompt verification by written Rx. Presumably, this should be mailed to the pharmacist later in the day.

Even so, the telephoned Rx is still a potential malpractice trap. The

law requires that the physician be precise in his prescribing; it holds him liable for damages resulting from lack of explicitness. And the telephone transmits data with complete preciseness only when special precautions are used.

The first hazard of the telephoned prescription is that the pharmacist may misunderstand you. As spoken over the phone, the words "mild chloride" and "bichloride" may be, and actually have been, confused. If a mercury salt is being prescribed, the difference between "mild chloride" and "bichloride" could be the difference between life and death.

Mannitol and Manicole sound much alike over the telephone. So do Alphaden pills and Alophen pills. Six tablets a day of the former would give the patient a lot of vitamins; six tablets a day of the latter would really have him on the run.

Diphentoin is good for epilepsy and Diphenan for worms, but neither is good for the other patient. Tuinal is a sedative but Turenol is a chologogue.

[MORE→]

*This does not, however, change the rules for narcotic drugs subject to the Harrison Act.

By Henry A. Davidson, M.D.



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There are dozens of such homonyms in pharmacy, many of which can be confused over the phone. Indeed, the wonder is that most telephoned prescriptions *do* turn out right. The margin for error, however, remains large and serious.

How to Play Safe

One precaution is to spell out the name of the drug. You may feel foolish doing so; but you'd feel a lot more foolish and remorseful if the patient got something you hadn't intended. It's a good idea, too, to ask the pharmacist to read the prescription back to you.

Another precaution is to give specific usage instructions to the pharmacist as well as the patient. Suppose a patient is told, for example,

to take a teaspoonful every four hours; but the pharmacist is told only to label the bottle "As Directed." What happens if the patient thinks he was instructed to take *four* teaspoonfuls every *hour*?

This could lead—in fact, has led—to a malpractice suit. All the doctor can fall back on then is his own recollection. Yet if he'd given usage instructions to the pharmacist, too, the label on the bottle would have protected both of them.

The pharmacist also ought to be told if the medication is intended for a child. That's a double check against your accidentally prescribing adult doses. It's the oral equivalent of the "Age" line on a printed Rx blank.

It seems wisest, too, to tell the

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Journal of the American Medical Association 149:729 (June 21) 1952.

Kuzell, W. C., and others: Phenylbutazone (Butazolidin®) in Rheumatoid Arthritis and Gout.

Gout: "... 25 of the 48 gouty patients experienced a complete remission in 48 hours or less."

Journal of the American Medical Association 150:1087 (Nov. 15) 1952.

Steinbrocker, O., and others: Phenylbutazone Therapy of Arthritis and Other Painful Musculoskeletal Disorders.

Osteoarthritis: In 63 per cent "... there was improvement of functional capacity ranging from slight to complete, with striking enhancement of coordinated movements. ..."

Journal of the American Medical Association 150:1084 (Nov. 15) 1952.

Stephens, C. A. L., Jr., and others: Benefits and Toxicity of Phenylbutazone (Butazolidin®) in Rheumatoid Arthritis.

Spondylitis: "Of the 32 patients ... 25 patients (80%) showed 3 to 4 plus subjective improvement."

Bulletin on Rheumatic Diseases 3:23, 1952.

Kuzell, W. C.: Phenylbutazone (Butazolidin®).

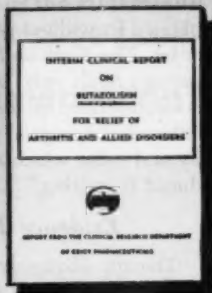
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pharmacist *not* to renew a telephoned Rx without your subsequent order. The Durham-Humphrey Act permits refills only "if such refilling is authorized by the prescriber, either in the original prescription or by oral order which is promptly reduced to writing."

Evidence Helps

Though obviously desirable, it isn't easy to make a written memorandum of every telephoned prescription. Sometimes, for example, the Rx may have to be phoned in from a pay station; and in the cramped quarters of the booth, you may not bother making any written notes. But you may be more inclined to do so after hearing about this case:

The parents contended that their child's death was due to an excessive dose of a phoned-in prescription. The child had been given one-gram tablets of an antibiotic that was nor-

mally given in 0.25-gram tablets to children. The physician testified he was "morally certain" that, in speaking to the pharmacist over the phone, he had called for the smaller tablet. But the pharmacist's scrap-paper memo showed "one-gram" tablets. The druggist also explained that the physician had never indicated his Rx was for a child.

If this doctor had been able to produce even a rough memo, scribbled on the back of an old envelope, it would have helped. As it was, he had not one shred of evidence to show that he had prescribed the correct dose. Result: He was held partly accountable for the death.

In this age, the telephoned prescription may be an occasionally necessary expedient. However, it remains just that: an expedient. It probably never will, and it probably never should, replace the old-fashioned practice of putting your pen to an Rx blank. END

This End Up

● The rather pompous woman was shocked to hear the clinic nurse instruct her to remove her panties.

"What?" she exclaimed. "Take them off for an *ear* examination!"

The nurse looked again at the case history. Sure enough, she'd confused Mrs. Fine with Mrs. Kline; so she hastily assured the woman she could keep her clothes on.

News of the boner quickly spread through the clinic. So when the gynecologist bumped into the otologist later in the day, he said gravely, "Hello, Jim. I hear you're now doing ear examinations—by long distance."

—RUTH M. AUCHENBACH

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(100,000 units* per teaspoonful)

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(50,000 units per dropperful—
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Do You Have Trouble With Dentists?

***Misunderstandings between
M.D. and D.D.S. are often
generated by a mutual patient.
Here's how to avoid friction***

● Certain side effects of dental treatment can be unexpectedly painful—for the dentist. Not long ago, a young woman leaned back in my chair, opened her mouth, and said: "I haven't been following the diet you prescribed. My doctor told me not to."

The "diet" was an urgent recommendation that she eat more green vegetables. I couldn't think why anyone should object, except possibly the patient herself. Nor, if her physician *had* objected, could I think why he hadn't let me know his reasons. So I made my "Oh?" as casual as possible, and took my time about selecting a probe.

"I just happened to mention it to him," the lady in the chair went on. "And he said I needn't worry about a special diet as long as my appetite and weight stay normal."



That called for a change of subject. I could see I'd have to persuade her all over again that improved eating habits would mean fewer dental treatments; but not *that* day. I doubted that her confidence in either dentistry or medicine would be increased by what she might in-

By Lewis J. Bell, D.D.S.
patient education. The illustrations
are by Stig Schultz-Haudt, a re-
search associate in dentistry.

***The author is an associate professor at a large dental school, where he teaches dental economics and**

terpret as a disagreement between the two professions.

Of course, there was no real disagreement. What had thwarted my dietary plan was just a careless remark tossed off by a busy physician.

I'm convinced, from experience that the fine art of cooperation between physician and dentist has reached a high level. I believe that their mutual patients have been immensely benefited by these good relations. I even maintain that physician-dentist relations are almost as good as they *should* be.

But not quite. Or, at least—as in the story related—not always.



"The fine art of cooperation between physician and dentist . . ."

Probably there are fewer *disagreements* between physicians and dentists than between any other two professions. But *misunderstandings* are something else. They crop up where least expected; and sometimes they have serious consequences for dentist, patient, and physician.

What causes them? Mostly, as I see it, the existence of a few specific stumbling blocks.

I teach at a dental school, and my courses are largely concerned with relationships between dentists, physicians, and patients. One of the easiest points for me to demonstrate to students is that every stumbling block between dentists and medical men has two sides—and that the physician's side is the easier to stumble on.

Why? Because the average M.D. has only occasional contact with dentistry, while the dentist must work with many branches of medicine in nearly every phase of his work.

It goes without saying that you, as a physician, don't *want* to trip over hard-to-see stumbling blocks. But how can you avoid them? Here are a few suggestions:

Those Casual Answers

1. *Avoid making broad statements that may be misinterpreted by patients.* Often, for instance, a patient who is also receiving dental treatment may ask for your opinion on some feature of it. That's perfectly all right. But sometimes he

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In severe hypertensive states in which prompt relief of distressing symptoms is imperative or in which continued elevation of arterial tension may become life-threatening, the parenteral solutions of Veriloid offer a valuable means toward these therapeutic objectives. They are contraindicated only in pheochromocytoma, coarctation of the aorta, digitalis intoxication, and high intracranial pressure not secondary to hypertension.

Since the parenteral solutions of Veriloid are potent hypotensive agents, physicians should familiarize themselves thoroughly with their actions and details of dosages and administration, as presented in the leaflet packed with each ampul.

Stearns, N. S., and Ellis, L. B.:
New England J. Med. 246:397
(Mar. 13) 1952.

Kauntze, R., and Trounce, J.:
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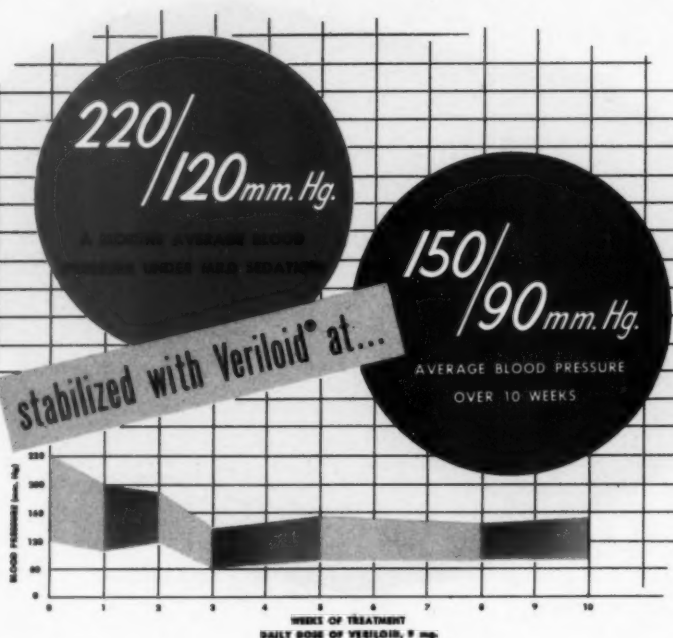
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Kauntze, R.: Proc. Royal Soc. Med. 45:276 (May) 1952.

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The therapeutic effect of Veriloid shown above was reported by Kauntze and Trounce in *Lancet*, December 1, 1951. As with all other hypotensive drugs, not every patient will respond equally well. But diligent patient supervision, careful adjustment of dosage and *modus vivendi*, and the safety factor inherent in the side actions of Veriloid will produce similar results in a goodly percentage of patients, a percentage high enough to merit the use of Veriloid in every case of hypertension, for a period long enough to determine the patient's response.

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puts his questions so disarmingly, and you answer so casually, that he sees implications in your reply that aren't really there.

I doubt that any responsible physician would deliberately tell a patient to ignore his dentist's advice. Even if the M.D. had good reasons for believing the advice questionable, he'd generally be discreet enough to compare notes first with the dentist.

But many misunderstandings are generated, I suspect, by the patient. Suppose a person is unhappy about a dentist's diet prescription. Suppose the patient one day asks the physician, "Doctor, is there any good reason why I should stuff myself with green vegetables, which I detest?" Then suppose the physician casually replies that he would-

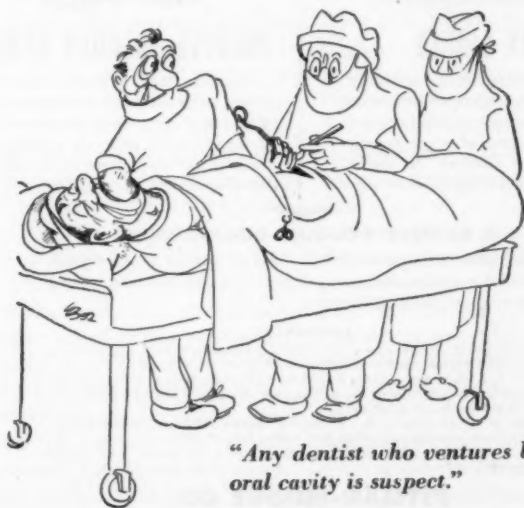
n't say so—that, as a matter of fact, he doesn't like vegetables himself.

The effect is translated thus in the dentist's office: "My doctor doesn't think I should follow the diet you gave me!" And the physician will probably never know that he helped create a minor crisis in dentist-patient relations.

Where did the physician stumble? If he'd given the question an instant's thought, my guess is that he'd have wanted to know what brought it up. Having found out, I'm sure he'd have worded his answer more diplomatically.

When Patients Return

2. *At least give careful consideration to the dentist's tentative diagnosis when he refers a patient back to you for further medical examina-*

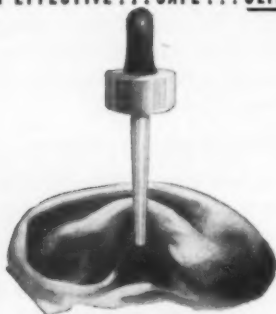


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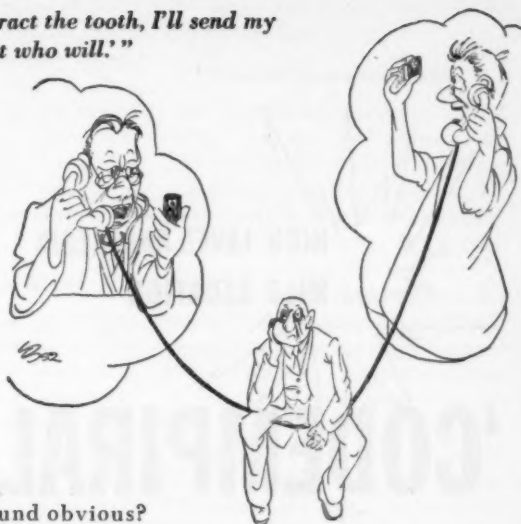
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"If you won't extract the tooth, I'll send my patient to a dentist who will."



tion. Does that sound obvious? That's what I'd have said—before some events like the following became known to me:

A dentist, interviewing a new patient about his general physical condition, found reason to suspect a heart ailment. He telephoned the man's physician, who was unimpressed—since he'd examined the patient a few months earlier and found nothing wrong. But he promised to look into the matter.

The physician apparently did make some sort of examination. At the end, he assured the patient that he was as sound as any man of his age could expect to be. And he added a few words to the effect that any dentist who ventures beyond the oral cavity is automatically suspect.

The immediate result was rough on the dentist. Though he didn't

lose his patient, he had lost a good share of the man's respect and confidence.

But what happened next was even rougher on the patient: He suffered a heart attack.

An extreme example? Perhaps—but not so far-fetched as you might think.

Sometimes a physician rejects a dentist's diagnosis merely through personal pride; he believes he'd have been the first to spot a patient's disorder, if any existed. He may rely on the findings of an examination made many months before. Or he may simply feel that opinions not originating with other physicians aren't worth considering.

The men who have these atti-

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tudes usually aren't aware of them or of the harm they can do. Such men know, of course, that today's dentist has had enough medical training to make good use of the diagnostic tools in his possession. And these physicians know—or should know—that the reputable dentist doesn't practice beyond his specialty.

What Dentists Want

3. *Be willing to share your case history with the dentist and to consult with him when he requests it.* Presumably, like most physicians, you make a point of cooperating in this respect. But some men don't.

The M.D. who fails to cooperate usually belongs to the old school. His opinion of dentistry dates from the time when the tooth-puller relied on brawn rather than brain. But when finally prevailed upon to discuss a patient's treatment with an up-to-date dentist, he's apt to change his mind.

He soon admits that medical guidance is often essential to good dental work. Few modern dentists will undertake extensive treatment without it if the patient has major systemic ailments.

A physician's advice may be needed when questions about anesthesia or sedation arise. When soft foods prescribed for ulcer patients interfere with the control of oral disease, dentist and physician may have to work out a compromise diet. Certain medications damage diseased teeth and gums, and the den-

tist needs the physician's help to offset their bad effects.

Flat Recommendation

4. *Beware of specifying dental procedures that the dentist may find inadvisable.* This is another stumbling block that trips the old-school medical man more often than his younger colleague. What happens is something like this:

The physician, tracking down the source of a low-grade infection, suspects a tooth that obviously has seen better days. So he sends the patient to the dentist with instructions to have the tooth pulled.

The dentist may concur in the M.D.'s opinion, of course. On the other hand, he may find the tooth innocent of mischief. So *he* recommends leaving it alone.

At this point, practically anything can happen. Patient and physician may gladly accept the dentist's opinion. Or the patient, having more confidence in the physician's verdict, may think less of the dentist for disputing it. Or—and this is the great danger—the physician may insist on standing by his diagnosis.

I've heard of M.D.'s who have said to dentists in such situations: "If *you* won't extract the tooth, I'll send my patient to a dentist who will." Every so often, that's exactly what happens—with nobody better off in the long run.

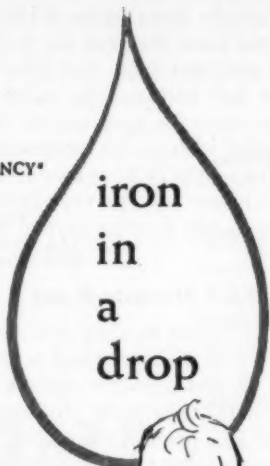
It's the dentist's business to know his specialty better than anyone else. If the physician doesn't feel this is true of a particular dentist, let him

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(1) Youmans, J. B., in Handbook of Nutrition, Chicago, American Medical Association, 1951, p. 577; (2) Hansen, A. E., in Mitchell-Nelson Textbook of Pediatrics, ed. 5, Philadelphia, W. B. Saunders Co., 1950, p. 106; (3) Heck, F. J.: J.A.M.A. 148: 783, 1952.



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75 mg. (about
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choose another in whom he has more confidence—and then make his referral with no strings attached.

When Economy Counts

5. *Don't advise patients to postpone needed dental care because of the possible financial burden.* Some M.D.'s have done this when patients of modest means already face large medical bills. The excuse is that not many dental disorders (apart from a raging toothache) are considered real emergencies.

Yet the patient may be ill advised without a word from the dentist. While the cost of certain procedures often poses a problem, solutions

have been worked out by dentists in a wide variety of cases.

It's true that some people can't afford all the services they should have at one time, even with dental budget plans. But there's another alternative that shouldn't be overlooked—namely low-cost preventive care, which can make the waiting period safer.

Physician and patient may both be agreeably surprised at what can be accomplished without an extravagant outlay. The M.D. who's aware of this fact and advises accordingly will not merely help his patient; he'll help improve physician-dentist relations, too. END

No Fiddling

● "Make your profession the chief object of your life, and avoid extraneous pursuits . . . Divorce medicine from all other vocations, however important, respectable, or lucrative—from the drug business, preaching, speculating in petroleum or salt; being partner in a saw-mill, owner of a dry-goods store, or dealing in cattle, or horses; nor be equally interested in the practice of medicine and in school-teaching, or in pushing the jack-plane, or following the plow; giving public readings or preaching on subjects not connected with medicine; scribbling poetry; fiddling or singing at concerts; or base-ball playing, rowing-matches, public amateur photographing, etc., because medicine is a lofty intellectual pursuit, and the public cannot appreciate you or any one else in two dissimilar characters or incompatible callings: half-physician and half-druggist, or three-eighths physician and five-eighths politician, or one-third physician and two-thirds sportsman, or other similar mixture of incongruities, for it is in medicine as in religion: Ye cannot serve two masters."

—From "*The Physician Himself*," by D. W. Cathell, M.D., Philadelphia, 1908.

PEDIATRICS

Prepared In The Interests Of The Profession By The Pediatrics Consultant Staff Of H. J. Heinz Company

BULLETIN

Child ACCIDENTS

WITH REDUCTION of mortality and morbidity from many diseases, accidents are now the leading single cause of child deaths. One-third of our child deaths are due to accidents.

● **The traditional duty** of us physicians is to *treat* accidents, but it is also our duty to shoulder certain responsibilities for *prevention*. During home visits to the new mother, and in routine child health care, we can easily give effective parental instruction.



● **Descriptions** of possible accidents would fill volumes and statements of general principles may cause only uncritical parental fear and are usually ineffective. Certain specific situations, however, cause a high percent of accidents and can be specifically prevented. The dangers of open safety pins in bed, the child left alone on a table or couch, a casual permissive attitude towards peanuts during play, hot dishes on the edge of the stove, can be taught by only a word to the eager young mother. Inspection of closets and the space under the kitchen sink for poisonous materials, can warn the mother of the young crawling child of many common dangers.

● **A physician's word** carries great weight. Our sacrifice of a little of our time may well prevent many deaths.

NOTE: These bulletins are designed to help disseminate modern pediatrics knowledge to the general medical profession and will appear monthly in Medical Economics.

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Letters to a Doctor's Secretary

To keep the aide on her toes: a suggested reading list, and an over-all quiz

● Dear Mary:

My instructions to you end with this letter. In the others I've done my best to outline the fundamentals of your position, but you've no doubt learned by now that there are a thousand details—matters of attitude, method, and policy—that you must work out for yourself.

As a final guide, I'd like to suggest some books for you to consult from time to time. The following list isn't complete, of course; keep on the lookout for other helpful volumes. And don't forget that many of the journals Dr. Barrie reads contain valuable information for you, too. Build yourself a little professional library that will make you one of the best informed and most up-to-date medical secretaries in—well, anywhere!

I haven't included publication dates in the following lists, since revised editions of many of these books are constantly being issued. Naturally, you'll want to buy the most recent edition you can find. I haven't mentioned prices either, because they're variable. And, too, you may be able to pick up inexpensive secondhand copies of some of the books.

Here are two that you'll probably refer to a dozen times a day:

WEBSTER'S COLLEGIATE DICTIONARY.
Springfield, Mass.: G. & C. Merriam Company

THE AMERICAN ILLUSTRATED MEDICAL DICTIONARY. By W. A. Newman Dorland. Philadelphia: W. B. Saunders Company

Three books that discuss some of the vexing problems of secretarial procedure:

STANDARD HANDBOOK FOR SECRETARIES. By Lois Irene Hutchinson. New York: McGraw-Hill Book Company [MORE→

By Anna Davis Hunt

**These letters were published originally as a series in MEDICAL ECONOMICS, signed with the nom de plume Myrna Chase. In response to a great many requests, they have*

been reprinted in revised and up-dated form. The complete current series, of which the present letter is the last, is now available in book form.

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Furacin Vaginal Suppositories are being used preoperatively to eradicate accessible bacterial infections of the cervix and vagina.

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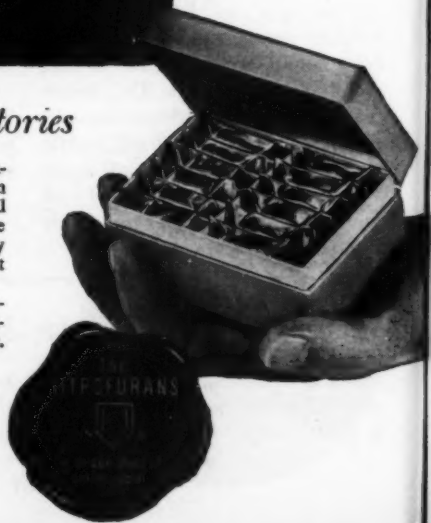
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Literature on request

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HANDBOOK FOR THE MEDICAL SECRETARY. By Miriam Bredow. New York: McGraw-Hill Book Company

THE PHYSICIAN'S BUSINESS. By George D. Wolf, M.D. Philadelphia: J. B. Lippincott Company

Next, a couple of volumes that will give you a background of medical knowledge:

TEXTBOOK OF ANATOMY AND PHYSIOLOGY. By D. C. Kimber, C. E. Gray, C. E. Stackpole, and L. C. Leavell. New York: The Macmillan Company

ESSENTIALS OF NURSING. By Helen Young and Eleanor Lee. New York: G. P. Putnam's Sons

To help you understand your patients, yourself, and your relation to one another:

PSYCHOLOGY FOR NURSES. By Bess V. Cunningham. New York: Appleton-Century-Crofts

First Aid, Too

For emergencies that may arise while the doctor is away from the office:

AMERICAN RED CROSS FIRST AID TEXTBOOK. Philadelphia: The Blakiston Company

And since in the long run your success depends not merely on your efficiency but also on the kind of person you are, there are two books—one new, the other quite old by now—that are well worth reading and rereading:

ANITA COLBY'S BEAUTY BOOK. By Anita Colby. New York: Prentice Hall

HOW TO WIN FRIENDS AND INFLUENCE PEOPLE. By Dale Carnegie. New York: Simon and Schuster (Also available in a paper-covered Pocket Books edition)

With those books, with my letters, with your own experience and good sense, and with the doctor's helping hand, you're well launched on your career. I haven't the slightest doubt of your continuing success, Mary, and I'm sure Dr. Barrie would agree with me.

Test Your Knowledge

Just for your own amusement and instruction, though, I've thought of a way for you to test your knowledge of a secretary's duties. Attached to this letter is a short quiz for you to give yourself [see page 140]. It includes some questions about facts that I've covered in these letters; there's also a checklist of your efficiency, your attitude toward patients, and your usefulness to the doctor. I suggest you review the test every now and then, just to be sure you aren't forgetting some important aspects of your duties.

Why not take it right now? My guess is that you'll make a perfect score. If you don't, then I'm sure you soon will, if you keep the enthusiasm for your work that has endeared you to Dr. Barrie—and to me!

Affectionately,
Myrna Chase

Quiz for a Doctor's Secretary

[For answers, see page 149]

Section A

Each question in this section offers three possible answers. Check the right one.

1. Don't try to handle a telephone call yourself if it's a request for (a) an appointment (b) a contribution to charity (c) renewal of a prescription
2. While patients are in the reception room, you may (a) catch up on correspondence (b) make collection phone calls (c) post accounts
3. When answering the phone, you say: (a) "Standard 7789" (b) "Dr. William Barrie's office" (c) "Doctor's office"
4. The following must never be kept waiting during office hours: (a) other doctors (b) detail men (c) patients without appointments
5. The telephone rings while the doctor is examining a woman patient. You (a) let it ring (b) go to answer it, leaving the door ajar (c) go to answer it, closing the door behind you
6. During office hours, you spend as much time as possible in the (a) reception room (b) surgery (c) examining room
7. When taking a patient's temperature, you leave the thermometer in his mouth (a) one minute (b) three minutes (c) five minutes
8. Never pay by check for (a) office rent (b) car repairs (c) postage due
9. Patients' bills should be mailed every month by the (a) first (b) fifteenth (c) twenty-ninth
10. Fee adjustments are seldom made for (a) house calls (b) operations (c) long courses of treatment
11. Never give large accounts to a collection agency until (a) five years have passed (b) the statute of limitations for malpractice claims has expired (c) you have sent three letters threatening to give the account to an agency
12. A subject you may talk to your friends about is (a) treatment of patients (b) the high regard the doctor's patients have for him (c) the doctor's income

[MORE→]

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AVC Improved is indicated in a wide range of infections of the exo-cervix, vagina and vulva:

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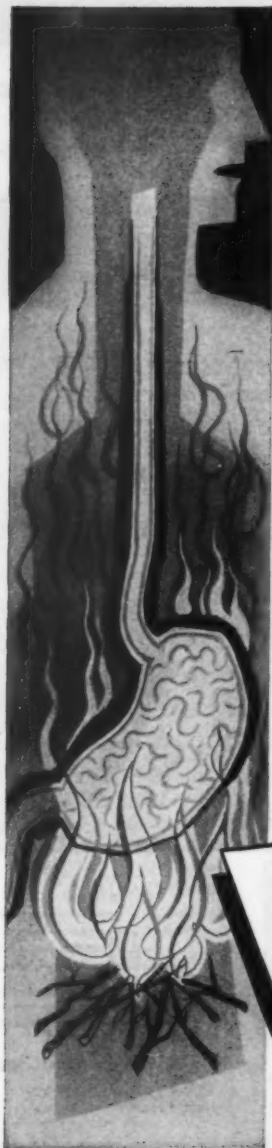
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Secretary's Quiz (Cont.)

13. Information about a patient may safely be given to (a) another doctor (b) an insurance company (c) the patient's friends
14. All office bills are paid by check on the following day of the month: (a) the first (b) the tenth (c) the twenty-first
15. The doctor's signature, not yours, should appear on (a) letters acknowledging payment (b) collection letters (c) refusals to contribute to charity

Section B

This is a test of your knowledge of medical terminology. Match each prefix, root, or suffix in the left-hand column with its meaning in the right-hand column.

1. PREFIXES

- (a) erythro-
- (b) hypo-

below, deficient
difficult, painful

(c) tachy-

(d) dys-

(e) hetero-

other

fast

red

2. ROOTS

- (a) cost
- (b) enter

intestine
poison

(c) neph

(d) leuc

(e) tox

rib

kidney

white

3. SUFFIXES

- (a) -algia
- (b) -emia

inflammation
feeling, sensation

(c) -itis

(d) -esthesia

(e) -oma

tumor

pain

blood

Section C

Efficiency test. Answer "Yes" or "No" to each question:

1. Does your attitude reflect admiration and loyalty to the doctor?
2. Is your typing neat, without strikeovers or smudges?
3. Do you tell slow-paying patients the doctor needs the money?
4. Do you collect small fees at the time service is rendered?
5. Does the doctor's checkbook agree with his bank statement?
6. Do you work on statements during office hours?
7. Do you let the reception room become a "symptom exchange"?
8. Do you make bank deposits every day?
9. Are you always seeking ways to improve your efficiency?
10. In the examining room, do you assign a definite place to each article and keep it there?

[MORE→]

pain

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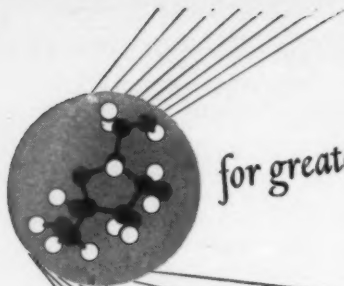
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Secretary's Quiz (Cont.)

11. Do you avoid interrupting the doctor while he's with a patient?
12. Do you always carry a small pad of paper and a pencil in the pocket of your uniform?
13. Do you do everything you can to save the doctor's time for his professional duties?
14. Do you write as many letters as you can, yourself?
15. Do you send receipts for payments by check?
16. Do you bear in mind that your voice, manner, and conversation are taken as reflections of the doctor's attitude?
17. Do you use the office phone for chatty personal calls?
18. Do you carefully avoid giving patients advice on medical matters or expressing opinions on them?
19. Does your voice express cheerfulness and sympathetic interest?
20. Do your books always balance?
21. Do you sometimes have trouble finding a patient's case history?
22. Are the reception-room magazines new and neatly arranged?
23. Are you careful never to do anything to detract from the doctor's reputation or cause patients to go elsewhere?
24. Do you get a new patient's full name, given name of husband or wife, parent's or guardian's name if patient is a child, whom referred by, and correct home and business addresses?
25. Are you careful never to use stained or torn linen in the examining room?
26. Do you boil sharp instruments like knives and scissors?
27. Do you escort women patients into the examining room and tell them specifically and clearly what they are to do there?
28. Are you ever discourteous to visitors or telephone callers?
29. Before office hours begin, do you make sure every room is in perfect order?
30. Do you ever wear a bright handkerchief in your uniform pocket, or earrings or beads?
31. Do you always get to the office a little early?
32. Do you make sure the doctor dictates histories on every patient?
33. Do you always make carbon copies of case histories and letters?
34. In dealing with patients who are slow to pay, are you ever censorious or sarcastic?
35. Do you ever "steal" another doctor's patient?

[Answers on 149]

LATE FINDINGS

on the value of CITRUS

Where?	Why?	How?	References
in ABORTION	to help mitigate formation of hematomas in Rh-negative mothers; and in toxemias	citrus fruits and their concentrates and vitamin C supplement	Surg., Gynec. & Obst. 94:257, 1952
in ALCOHOLISM	to force fluids; and help assure adequate nutrition	vitamin C orally in large doses after acute stage has been brought under control	Virginia M. Month. 79:70, 1952
in AVIATION MEDICINE	to replenish vitamin C lost in hypoxemia or hyper-ventilation; and provide quick energy	liberal quantities of fruit or fruit juices	J. Aviation Med. 21:283, 1950; Mil. Surg. 108:125, 1951
in BURNS	to improve nutrition prior to grafting; and promote healing	large doses of vitamin C as soon as patient can eat	Am. J. Surg. 83:746, 1952; GP 5:35, 1952
in OBESITY	to appease appetite during reducing; and combat hypoglycemia	50 calories of citrus fruit (e.g. 4 oz. fresh orange juice) before lunch and dinner	Postgrad. Med. 9:106, 1951
in PEPTIC ULCER	to avoid vitamin C deficiency; aid healing and assist in weight control	2-3 oz. strained citrus fruit juice in water (or milk) at end of meal	Sandweiss: "Peptic Ulcer," 1951; "Low Cost Therapeutic Diets," 1952
in RHEUMATIC CONDITIONS	to maintain good nutrition without obesity; provide purine-free food; and help reduce inflammation	for arthritis, high-vitamin diet; for rheumatic fever, orange juice 200 mg. daily; for gout, diet prominent in fruits, including citrus	Am. Pract. 2:577, 1951; "Current Therapy," 1952

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Answers to Secretary's Quiz

[SEE PAGE 140]

● Allow one point for each correct answer in sections A and B, two points for each correct answer in section C. Perfect score is 100.

- A. 1. (c) 6. (a) 11. (b)
2. (c) 7. (b) 12. (b)
3. (b) 8. (c) 13. (a)
4. (a) 9. (c) 14. (b)
5. (b) 10. (a) 15. (a)

- B. 1. (a) erythro- red
(b) hypo- below, deficient
(c) tachy- fast
(d) dys- difficult, painful
(e) hetero- other

2. (a) cost rib
(b) enter intestine
(c) neph kidney
(d) leuc white
(e) tox poison

3. (a) -algia pain
(b) -emia blood
(c) -itis inflammation
(d) -esthesia feeling, sensation
(e) -oma tumor

- C. The answer is "No" to numbers 3, 6, 7, 17, 21, 26, 28, 30, 34, 35; "Yes" to all others. **END**



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Go Slow in Cutting Fees, Once Set!

To set a fee, then reduce it, may be amply justified.

But it can also be risky

● Most doctors agree that a fee, once set, should not be reduced without compelling reason.

For a semi-indigent patient or for a member of a brother-profession, setting a lower fee may, of course, be in order. But then the fee is reduced in advance. The real problem arises when, *after* a reasonable fee has been set, something develops that justifies reducing or even waiving it.

Early this summer, on a swing around the country, I put a question to half a dozen former classmates of mine in as many cities: "Do you ever find it wise to reduce a fee once it's been set?" Here are some of their answers:

"Once in a great while," said one general practitioner. "Take a recent experience of mine, for example: For the first time in my career, I got to the hospital after the baby was born. I'd been rendering emergency care in another case, forty miles away, at the time. But delivery was precipitate. So there was no negligence on my part. I'd given good

prenatal and postnatal care; still, the family *had* agreed to pay my fee because they wanted *me* there on D Day. As it was, the interne did the delivery; and I thought it only decent to cut my fee, though there was no legal obligation to do so."

This G.P.'s attitude struck me as altogether reasonable. But another colleague told me of a situation in which I believe he may have made a mistake:

He was a surgeon who commanded good fees. A patient in modest financial circumstances, knowing what the fee would be, still agreed to pay it. The operation performed was a "routine" herniorrhaphy, but the patient developed a pulmonary embolus. Told about this, the family desperately scraped up money for round-the-clock nursing and for the employment of a consultant. Yet, while they had to go into debt to pay for these two items, the patient died.

"Under the circumstances," said the surgeon, "I just didn't have the heart to insist on the full fee. Instead I sent, and collected, a bill for one-third of it."

This was, I feel, a risky though well-intended gesture. The surgeon

By Henry A. Davidson, M.D.

had certainly not been guilty of malpractice; yet cutting the fee might have been viewed as a tacit admission of guilt. The fact is that he had done his job and was entitled to the full fee. Everyone knows there's an element of risk in any operation, and to make the fee correspond to the outcome would be to make every doctor a guarantor of results.

Some experienced surgeons have told me that in such situations they send their usual bill, plus a couple of follow-ups. Then if the family still has paid only in part, they can, if they choose, "forget" to send any further follow-ups. This constitutes a reduction of the fee by default, and may sometimes be the sensible thing to do. But when results are bad, an *announced* fee reduction may be construed as something other than altruism.

If It's a Hardship

Another former classmate, now a successful orthopedist, told me of a peculiar situation in which he felt a *post hoc* fee cut was wise: Like most surgeons, he does not demand top-bracket fees from low-income patients. For a certain type of open reduction he usually gets \$200. But a low-income patient generally pays only \$100—a pretty low fee—for the same service.

Not long ago, a family doctor asked him to see a \$45-a-week factory worker who had been hit, while on foot, by a recklessly driven car. The orthopedist was given to understand that the man would collect for both

personal damages and reasonable expenses; so he eventually submitted a bill for his usual \$200 fee. He did not offer a cut rate, as he would have if the patient had had no chance of collecting from the driver of the car.

As it worked out, though, the driver skipped town and was beyond legal process when the trial was called. The accident victim had to pay the surgeon out of his own badly depleted funds. So the surgeon, when told about this, sliced his fee to \$100.

This was obviously the right move. At first, I wondered about the ethics of having a higher fee schedule for liability cases than for private patients. But the surgeon here was ethically in the clear, since the fee for the liability case was actually his normal fee. This incident is representative of a type in which, through no one's fault, the doctor is misinformed about a patient's capacity to pay.

'Spare No Expense'

Several former classmates told me stories of persons who appeared so critically ill that the family, in panic, spoke of "sparing no expense." In one case, a well-known internist was called in consultation in the middle of the night to a town seventy-five miles away. Having been summoned on this "money-no-object" basis, he later charged the patient his usual long-distance consultation fee. It was then he learned that the "spare-no-expense" demand had

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In experimentally induced anemia, cobalt accelerates recovery from hemorrhage,⁽⁴⁾ overcomes the hemopoietic depression due to inflammation⁽¹⁰⁾ and is superior to iron, copper-iron, liver extract or vitamin B₁₂ in preventing the anemia produced by hypophysectomy.⁽²⁴⁾

See next page for clinical results

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Early reports on the use of cobalt in the treatment of human anemia have been extended and clarified by recent clinical investigations.

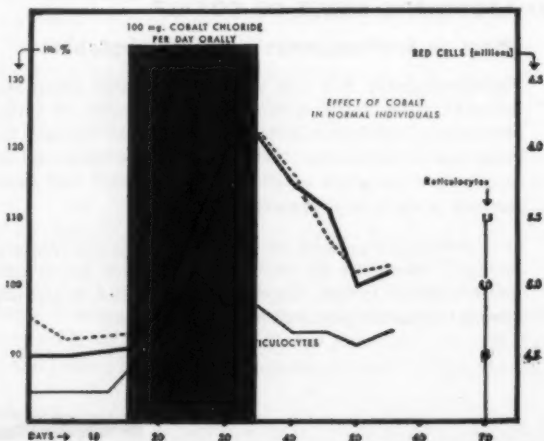
In anemic infants and children a definite pattern of response follows Roncovite therapy with increases in erythrocytes and hemoglobin levels. An average weekly gain of 250,000 erythrocytes and 0.6-0.7 Gm. of hemoglobin has been reported,^(18,27) despite the fact that many of the children so treated had failed to respond to iron.

Striking results likewise have been reported in adult secondary anemia.^(18,28,29)

As one investigator⁽¹⁸⁾ summarizes:

—the anti-anemia effect of cobalt can be expected in anemias where the bone marrow is capable of regenerative action. In such cases the hematopoietic effect is even greater than in the normal individual and is proportional to the severity of the anemia.

Marked erythrocyte increases, often of 50% or more of the initial value, are noted. In addition, if adequate iron reserves are present, parallel increases in hemoglobin are characteristic.



RONCOVITE

Roncovite (Cobalt and Iron) For Full Effect

The erythropoietic effect of cobalt does not depend on the presence of iron, since cobalt administration alone will cause erythrocytogenesis even in the presence of iron deficiency and may lead, in this way, to a hypochromia.⁽¹⁹⁾ Since iron is necessary for hemoglobin synthesis, Roncovite provides ferrous sulfate to insure adequate iron reserves and thus permits hemoglobin increases to accompany erythrocytogenesis under the influence of cobalt.

Clinical Applications of Roncovite

Cobalt therapy has given excellent results in secondary anemia accompanying chronic inflammatory diseases, infections, tuberculosis, chronic hemorrhage, pregnancy, iron deficiency anemia, idiopathic hypochromic anemia, erythrogenic hypoplastic and hypochromic microcytic anemia.

Dosage

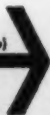
The recommended daily dose of 4 Roncovite Tablets provides 60 mg. cobalt chloride.

The recommended daily dose of 0.6 cc. of Roncovite Drops provides 40 mg. cobalt chloride.

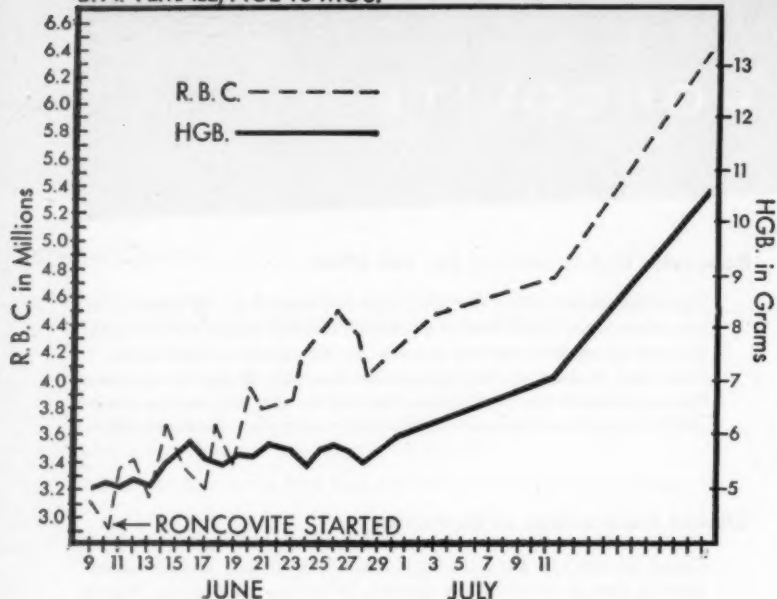
Both preparations provide, in addition, the necessary iron to maintain adequate iron reserve.

Daily oral doses of 60 mg. of cobalt chloride in adults, or 40 mg. in children and infants, have been shown to be effective hematopoietic stimulants, and are well tolerated. These doses may be increased if desired. Gastrointestinal side-effects, as evidenced by anorexia or nausea, are rare at the recommended dosage levels. The appearance of such side effects at higher dosage levels are an indication for reduction of the dose.

How To Prescribe Roncovite (next page)



B. N. FEMALE, AGE 15 MOS.



Preparations Available

RONCOVITE TABLETS

Each Enteric Coated, Red tablet contains:

Cobalt chloride.....	15 mg.
(Cobalt as Co.....)	3.7 mg.)
Ferrous sulfate, exsiccated.....	0.2 Gm.
(Iron as Fe.....)	60 mg.)

Average Adult Dosage: 1 tablet after each meal and at bedtime.

Supplied: bottles of 100 tablets.

RONCOVITE DROPS

Each 0.6 cc. contains:

Cobalt chloride.....	40 mg.
(Cobalt.....)	9.9 mg.)
Ferrous sulfate.....	75 mg.
(Iron.....)	15.1 mg.)

Average Dose: 0.6 cc. (10 minims) diluted with water, milk, fruit or vegetable juice once daily to infants and children.

Supplied: bottles of 15cc. with calibrated dropper.

Complete bibliography supplied on request.

LLOYD BROTHERS, INC. Cincinnati 3, Ohio

been motivated by panic rather than by prosperity; so he tempered his fee accordingly. In a sense, he had been imposed upon when told originally that money was no object. But that's one of the occupational hazards of the private practice of medicine.

In another instance, a family doctor asked a urologist to see a patient who was bleeding into the bladder from a large, eroded prostate. The patient, a salesman earning \$65 a week, was not questioned by the urologist about his finances. But he *was* told he needed a prostatectomy in a hurry.

'No Semiprivate Beds'

The only available hospital had an expensive private annex in a separate pavilion, with a variety of cheaper accommodations in the main building. Since the urologist's patient didn't qualify for a ward, and no semiprivate beds were immediately available, the family sold its car to raise cash for a week's advance payment on a bed in the annex. It then learned that the hospital required special nurses for all postoperative cases in the pavilion. So, to meet the second week's hospital payment and the nurses' bills, the family took up a collection from relatives.

The operation was successful, but the surgeon's fee came to \$750. The family income had been cut off during the salesman's illness, as he worked only on commission. So he asked the urologist for a reduction

of the bill. The latter's reply: "Anyone who can afford that private pavilion can afford my top fees."

Fortunately, the family doctor soon explained the situation, and the urologist lowered his bill to \$300—his usual fee for an operation on a semiprivate patient.

If the Society Insists

Sometimes a physician is wise to make a fee concession simply for the sake of his reputation within the profession. When I asked one of my former classmates, a cardiologist, if he would reduce a fee he had already set, his answer was prompt: "I would if the medical society asked me to." Then he told me this story:

The state Health Department had just established a new Child Health Division and had asked the state medical association to recommend a cardiologist as its part-time director. My colleague was eager for the job—and superbly suited to it. It had long been his dream to do something on a large scale about heart disease in childhood. He had, indeed, sparked the local public health group into needling the Commissioner to establish the new service.

Yet the state medical association turned thumbs down on his application. The reason: Three years earlier he had run afoul of his county society's then brand-new grievance committee. He had been treating a well-to-do patient for heart disease. Treatment covered five house calls



even
Pessimistic Pete
can be a
"regular guy" with
SARAKA®

for the physiological correction
of constipation

SARAKA Granules have proved their value over the years in helping make "regular guys" of constipated patients. The vegetable hydrogel, bassorin, provides soft, moist bulk while cortex frangula gently stimulates the atonic bowel. Even pessimistic patients who are resigned to being chronically constipated respond to the SARAKA combination of bulk plus motility that produces effortless elimination and satisfying daily regularity.

- SARAKA Granules (with cortex frangula)
- SARAKA-B Granules (without cortex frangula)
- SARAKA-D Granules (sugar-free)

Send for free clinical supply.

union pharmaceutical co., inc.
Montclair, New Jersey



and ten office visits. The bill, not itemized, was for \$300.

This \$300, he pointed out, was comparable to what the patient would willingly have paid a surgeon for an operation. He felt that his work was just as important as that of a surgeon—and a lot more time-consuming.

But the family brought the matter to the grievance committee. It was one of the first cases on the new committee's docket. Informally, the doctor was told that he had a right to set his own fees, but he was urged to reduce this bill to \$10 a house call and \$5 an office visit—that is, to \$100. The committee stressed the importance of the move in terms of public relations, particularly in view of the committee's newness. But my cardiologist friend refused. Instead, he sued and collected the full amount, plus court costs.

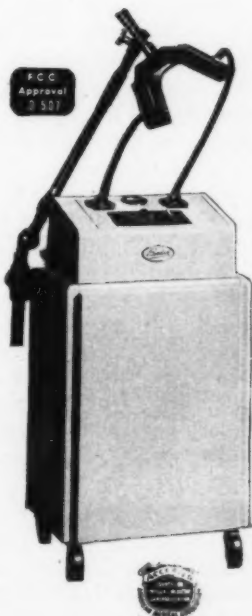
Now—three years later—his county society told the state association that it would never approve his selection for any public post, because he had been "uncooperative, insensitive to medicine's public relations, and unwilling to take the advice of his seniors."

Guaranteed Cure

Another former classmate had also learned something the hard way: He undertook to give injections to a chronic asthmatic, who asked: "Will these shots really stop my spells?" The doctor's answer: "I feel sure they will."

He admits now that he should

An Important N O T I C E



**If you are a user of old-type
diathermy equipment**

**ORDER YOUR NEW BURDICK
DIATHERMY NOW**

June 30, 1953 is the deadline established by the F. C. C. for use of old-type diathermy equipment. In order for users to be able to obtain conforming equipment in time for the deadline, orders must be placed immediately.

Orders placed now with a Burdick authorized dealer for the MF-49 F. C. C. approved diathermy will be filled within 90 days or less. Burdick dealers will be glad to demonstrate, in your office or their store, and without obligation, one of these Burdick F. C. C. approved units so that you can see its splendid performance before placing your order.

Burdick

THE BURDICK CORPORATION
MILTON, WISCONSIN

never have made such a promise. But he adds: "What *can* you say when the patient wants to know if the treatment will help? You can't say 'maybe' or 'possibly.'"

Two injections weekly for ten weeks resulted in a bill for \$100—and no relief for the patient, who thereupon balked at paying. When the doctor failed to cut his fee, there was a complaint to the medical society and some resultant scolding from the society brass hats. Since the doctor had "promised" a cure, they said, he had entered into a contract and failed to deliver. If the patient had been given to understand that there was no guarantee, he would have had no just grievance. But under the circumstances, a reduced fee was called for.

When Not to Cut

Sometimes it's more risky to cut fees than to insist on the full amount. A layman, as I've said, may consider that a reduction implies guilt on the part of the doctor. In the asthma case cited above, for instance, suppose that the patient had developed a complicating side-reaction. A cut fee then might have been construed as an admission that the treatment had been wrong.

I came across one odd case in which a layman even assumed that a humane gesture implied venality: A man charged with drunken driving pleaded, in his defense, that his stagger, his thick speech, and his confusion were due to barbiturates. He had been receiving phenobarbi-

tal daily on prescription of his family doctor.

The practitioner, an old man, was reluctant to drive to the courthouse (in a city forty-five miles away) to testify. But he finally said he'd do so if the family would pay him \$50 for his loss of time—a matter of six or seven hours.

The family agreed and he gave his testimony, but the judge wouldn't buy it. Instead, he fined the defendant \$250, and revoked his driving license.

Now the family was really in a hole, especially since the breadwinner's job required him to drive a car. Deciding that his testimony hadn't helped, and feeling sorry for his patient, the physician waived the fee.

A month later, he was asked by another driver accused of drunkenness to testify in court that he'd prescribed barbiturates for him too. This defendant was a complete stranger, and the doctor indignantly refused to perjure himself. The stranger's retort: "Don't kid me. When you waived your fee in that other case because your testimony didn't work, *everyone* knew what it meant."

The upshot of all this is that it seems safe to reduce a fee when results are good, but sometimes risky when results are bad. Under special circumstances, the fee may be reduced by default—that is, by not following up on the bill. But it's seldom wise to announce this in so many words.

END



April 5, 1951. Pruritic seborrheic dermatitis of 6 years' standing. Treatment over the years with various medicaments had failed.



May 24, 1951. After just 7 weeks with 'Pragmatar'. (After one day, itching stopped. After 1 week there was marked clinical improvement.)

in seborrheic dermatitis

PRAGMATAR*

highly effective in an unusually wide range of common skin disorders

'Pragmatar' is generally recognized as the most effective preparation available for seborrheic dermatoses, and for many other common skin disorders. Among them: common scalp disorders and dandruff; eczematous eruptions; fungous infections, including "athlete's foot"; pruritus, etc.

Formula: Cetyl alcohol-coal tar distillate, 4%; near-colloidal sulfur, 3%; salicylic acid, 3%—incorporated in a special washable base.

Smith, Kline & French Laboratories, Phila.

*T.M. Reg. U.S. Pat. Off.

Why 'Dexamyl' would be



Norman
Rockwell

This is the sixth of a series of Norman Rockwell portraits,
depicting patients typical of those you see in your everyday practice.

be

better than phenobarbital to allay her anxiety



You must see many patients like this one—who manifest nervous symptoms of anxiety. As Watts and Wilbur have said:

"The understanding and sympathetic physician realizes that almost every patient who consults him is worried and anxious."

J.A.M.A. 148:704 (March) 1952

Most physicians try to understand the causes of such anxiety, so that they may intelligently reassure the patient. And, in many cases, the doctor will prescribe phenobarbital or a similar depressant drug.

But, all too often, the patient's anxiety is caused by, or associated with, an underlying depression. And, in such cases, sedation with barbiturates—although it calms nervous symptoms—also deepens the underlying depression.

'Dexamyl'—a balanced combination of Dexedrine* Sulfate and amobarbital—relieves both the nervous symptoms of anxiety and the underlying depression. This is why you will find 'Dexamyl' better than depressant drugs for the management of anxiety.

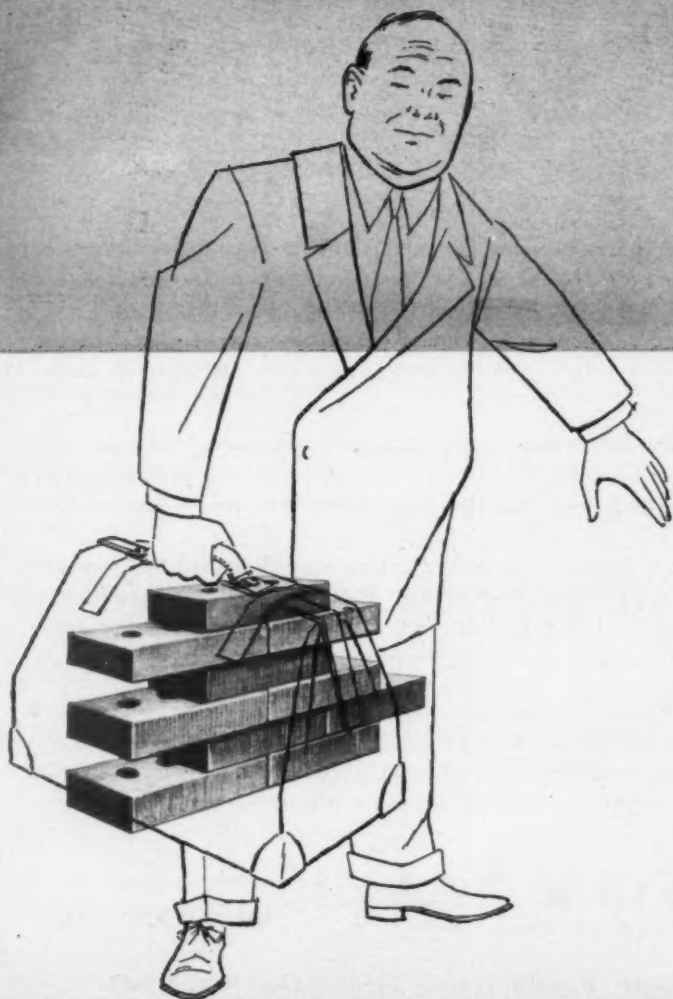
DEXAMYL[†] tablets and elixir

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off. for dextro-amphetamine sulfate, S.K.F.

†T.M. Reg. U.S. Pat. Off.

HE CARRIES A



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SYNDROX

... attacks obesity by:

- A** suppressing appetite
- B** elevating the mood, relieving the depressive state which frequently is the cause of over-eating

With Syndrox the problem of weight reduction can be kept under physician-control so that weight loss will not be too rapid. In the small dosage required, Syndrox has little or no side effects. Its onset is rapid and duration prolonged.

SYNDROX IS INDICATED ALSO IN:

- mild depressive states
- drowsiness—valuable to overcome sedative effects of antihistamines
- as adjunctive treatment in acute and chronic alcoholism



SUPPLIED: 5 mg. tablets (scored, green) in bottles of 100, 1000; also available—a pleasant-tasting elixir (colored amber) each 30 cc. (1 fl. oz.) containing 20 mg. Pints and gallons. Samples on request.



These Doctors Run a Library, Too

*Their county society has
its own medical library—
and so, they say, can yours*

● Most doctors want to keep up with medical progress. But some of them are stymied by not having easy access to the necessary books and journals. There are 369 medical libraries in the U.S.; but, unfortunately, they're not equally distributed over the country.

If you live in a big city or near a medical center, you may have several such libraries at your doorstep. But the average M.D. must rely on his own accumulation of books and periodicals—a costly and unsatisfactory solution—or on hospital librar-

ies, which are often inadequate.

In a few areas, physicians can borrow library material by mail (witness the Texas Medical Association's widely used package service). But such facilities have an obvious drawback: You can neither browse nor pick up a volume at a moment's notice.

So a number of county medical societies have begun to establish their own libraries. As yet, only thirty-five county associations scattered over eighteen states have done so; and, of course, they've had to start in a small way. Even so, county

By Jack Spears

**The author is executive secretary of the Tulsa County (Okla.) Medical Society.*



Tulsa doctors keep their library up to date by frequently adding equipment like the microfilm reader shown here. Robert E. Funk, chairman of the library committee, examines microfilm received from the Army Medical Library, as Chief Librarian Irma A. Beehler looks on. Browser in the background is Marshall O. Hart, president of the county medical society.

medical society libraries are already proving their worth.

To see how one such project works, take a look at the library of the Tulsa County Medical Society:

Back in 1932, doctors of this capital of the Oklahoma oil industry began to pool their books and journals. But it wasn't until six years later that an aggressive committee made the first real start toward a formal library. Then things began to snowball.

Within two years, members of the society contributed 3,500 back copies of specialty journals and textbooks. Fifty individual physicians agreed to contribute current copies of popular medical periodicals. The Tulsa County Medical Library, built on a solid base of current medical

literature, was started on its way.


By 1940, well over a hundred journals were being regularly routed into the library. From one small room, it quickly expanded into three big ones.

Meanwhile, the busy committee was completing files by ferreting out back copies of journals, and it was rounding up a sizable collection of basic textbooks. "We literally begged, borrowed, and stole our library," says Dr. David V. Hudson, one of the spearheads of the Tulsa project.

It was hard going for a while, but Tulsa's doctors grew more and more sympathetic. In 1941, they approved an increase in society dues, to permit the employment of a full-time librarian.

From then on, it was smooth sail-

6



A NEW
PRODUCT

Vallestiril

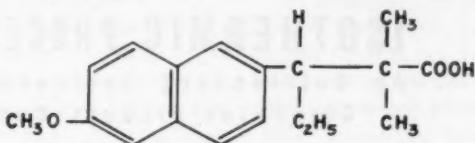
BRAND OF METHALLENESTRIL



Concerning Vallestril*...

Clinical evidence indicates that much estrogen therapy is accompanied by a high incidence of unfortunate side actions such as withdrawal bleeding, nausea and edema...

G. D. Searle & Co. presents VALLESTRIL...

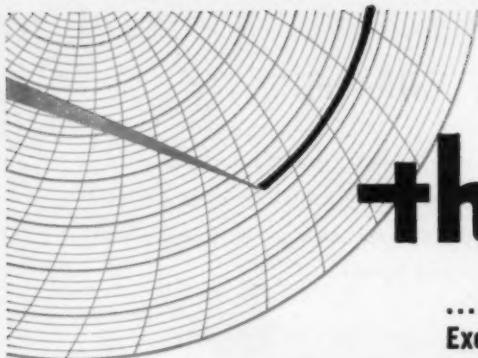


as an effective estrogenic substance with a *strikingly low incidence* of these undesirable side effects.

Vallestril is available in 3 mg. scored tablets. For treatment of the physiologic or artificial menopause—3 mg. (one tablet) twice daily for two weeks. Then a maintenance dose of one tablet daily for an additional month or longer if symptoms require continued administration.

SEARLE Research in the service of medicine

*Trademark of G. D. Searle & Co.



ARMOUR **thyra^r**

....The Premier Thyroid
Exclusively Prepared By

ISOTHERMIC PROCESSING

**An Outstanding Achievement in
Glandular Product Control**

WHAT IT IS: **thyra^r**—the entirely new, bovine thyroid preparation—is the culmination of decades of experience in glandular product control, with "isothermic processing" as the key to superior product uniformity. Positive isothermic control at every step in manufacture and exclusive use of bovine thyroid glands "quick-frozen" at the time of removal from the animal, provide a new, whole-gland preparation of highest purity. Distinct clinical advantages in all conditions requiring the metabolic action of thyroid are obtained with **thyra^r**.



ADVANTAGES: Complete efficacy of the whole gland • Greater uniformity of finished product • Elimination of unwanted organic matter • Double standardization—chemically assayed and biologically tested • Standardized equivalent to Thyroid U.S.P.—no dosage change required • Tasteless • New, small-sized, whole-thyroid tablet offers greater patient convenience.

HOW SUPPLIED: Tablets of $\frac{1}{2}$, 1 and 2 grains in bottles of 100 and 1000.

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PHYSIOLOGIC THERAPEUTICS THROUGH RESEARCH



ing. After a few months, the librarian had catalogued and shelved the books according to the Cunningham Medical Catalogue System. The budget was still slim, but chaos had given way to order.

Grateful for the new facility, Tulsa physicians showered the library with gifts. Many more of them contributed subscriptions to journals and new medical texts. Some gave their entire private libraries. Others left wills specifying gifts of valuable books and cash bequests.

Allied professions provided literature in nursing, dentistry, pharmacy, and biochemistry. Even the doctors' wives helped. They made the reading rooms a pleasant place to work in by adding comfortable chairs, tables, and curtains.

Finally, in 1947, cash gifts of several thousand dollars from Tulsa doctors paved the way for the establishment of a permanent endowment fund. This fund will eventually make the library self-supporting.

Today, it contains nearly 10,000 books, journals, and reprints. Two trained librarians keep up to date the files of 135 medical periodicals and tend to the requirements of over 300 monthly patron visits.

Among other improved services: convenient evening hours; weekly showings of medical and surgical motion pictures; microfilm reading facilities (that make it possible to secure almost any item of extant medical literature).

For other county medical societies that may be considering a simi-

Goodwill Gesture

Whenever I receive an announcement from a new M.D., I reply with a note worded something like this: "It was good to get your announcement and to note that you plan to practice here. If I can be of any assistance to you, just call on me. Meanwhile; let me wish you all possible success."

It's surprising how many of these doctors refer cases to my office, even though referrals are not my object and in some instances we've never even met. As one practitioner said: "When I was new here, you were the only man of your specialty thoughtful enough to send me a good-luck note."—M.D., NEW JERSEY

lar project, Dr. Robert E. Funk, chairman of the Tulsa library committee, offers the following advice:

1. Try to get an interested, aggressive committee—one that will roll up its sleeves and work.

2. Don't be afraid to start on a shoestring. The nucleus of the library will come from material lying dormant in professional offices. Once the embryo library gets under way, necessary funds will begin to pour in.

3. But don't expect to operate forever on a slim budget. When it's firmly established, the library should have adequate permanent financing.

4. Employ a trained librarian at



Prelude to asthma?

not necessarily...

Tedral, taken at first sign of attack, often forestalls severe symptoms.

in 15 minutes... Tedral brings symptomatic relief with a definite increase in vital capacity. Breathing becomes easier as Tedral relaxes smooth muscle, reduces tissue edema, provides mild sedation.

for 4 full hours... Tedral maintains more normal respiration for a sustained period—not just a momentary pause in the attack.

Prompt and prolonged relief with Tedral can be initiated any time, day or night, whenever needed without fear of incapacitating side effects.

Tedral provides:

theophylline	2 gr.
ephedrine	$\frac{3}{8}$ gr.
phenobarbital	$\frac{1}{8}$ gr.

in boxes of 24, 120 and 1000 tablets

Tedral

WARNER-CHILCOTT

Laboratories, NEW YORK

the earliest opportunity, and use standard library practices.

5. Subscribe to journals as much as possible, instead of soliciting them. While the latter method is often expedient at the start, it becomes cumbersome and unsatisfactory as patronage and services grow.

6. Make it a long-term project, and plan for expansion of your physical facilities.

"As a tangible expression of what organized medicine can do in working together, our medical library has strengthened our whole program of activity," says President Marshall O. Hart of the Tulsa County Medical Society. "It has proved an ample justification for increased dues."

Tulsa is a big city, of course; and most medical-society-sponsored libraries are located in cities of 150,000 or more. But there's no reason

why similar projects shouldn't be established in smaller places.

There are, naturally, certain major expense items: rent, salaries (a minimum of \$275 a month for a good librarian in most areas), binding costs, and subscription prices. So the finances may seem a bugaboo—especially for societies with fewer than 100 members. But a little money and a lot of elbow grease can go a long way toward solving the problem. Community hospitals, for example, can be asked to help share operating costs and provide physical facilities.

Whatever the efforts involved, the result may well justify them. After fourteen years as a patron of the Tulsa County Medical Society library, a local doctor summed up his reaction thus: "I don't know how we ever got along without it." END

Indirect Route

● A young woman got the hiccups while kibitzing a men's card game at a Fort Worth country club.

Minutes passed. The hiccupping continued.

The card players squirmed with annoyance. One of them had a waiter bring the intruder a glass of water. She drank it, but continued to hiccup.

Suddenly one of the players, a doctor, swung around to the woman and roared:

"Madam, are you pregnant?"

She flushed and replied angrily: "Certainly not!"

"Are you quite sure?" he persisted.

The woman quavered with rage: "I'm not even married!"

"No," said the doctor, returning to his cards. "And you're not hiccupping any more either."

—HELEN BULLOCK

When Temptation

Obscures the View



When visions of better health and a new figure give way to the lure of forbidden foods, it's time to consider **DESOXYN Hydrochloride**. **DESOXYN** gives new life to the diet by curbing the appetite and uplifting the patient's morale. Weight for weight, **DESOXYN** is more potent than other sympathomimetic amines so that *smaller doses* can produce the desired anorexia with a *minimum of side-effects*. One 2.5-mg. or 5-mg. tablet before breakfast and another about an hour before lunch are usually sufficient. In addition, **DESOXYN** has a *faster action, longer effect*. Try it—in obesity, in convalescence or prolonged illness—in all conditions indicating a central stimulant. **Abbott**

Prescribe

Desoxyn[®] *hydrochloride*

(METHAMPHETAMINE HYDROCHLORIDE, ABBOTT)

How to Save Taxes on Interest

*Some of the interest you get may be tax-free; and
some of the interest you pay may be tax-deductible.*

This article tells when

● You buy an automobile on installments; but since the interest rate isn't clearly specified in the contract, the tax collector won't let you deduct the carrying charges. On the other hand, you own a corporate bond; and he tells you that you needn't report part of the interest on it.

Is it any wonder you're confused? Is it surprising that interest income and interest payments are among the most mishandled items on Federal tax returns?

Fortunately, you can thread your way through the confusion by following a few simple rules. Here they are—with, in most cases, an important exception to the rule:

Rule: You must pay taxes on interest you receive on corporate bonds, bank deposits, mortgages, notes, matured insurance, deferred legacies, and Federal obligations issued on or after March 1, 1941.

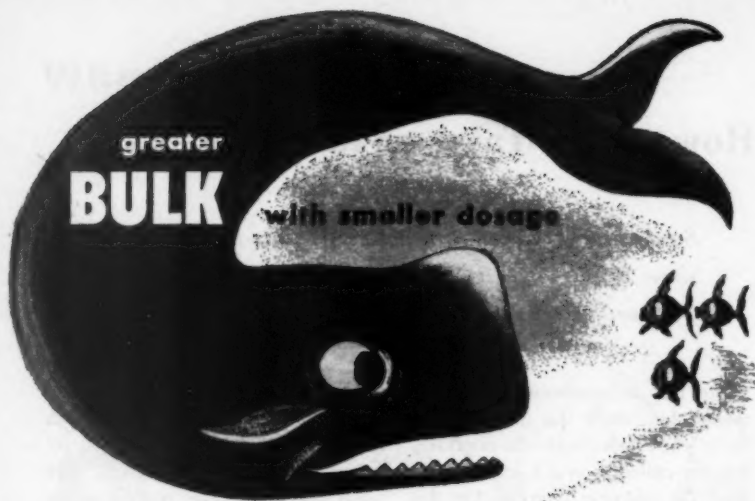
Exception: Accrued interest paid on a bond bought originally at a price reflecting that accrued interest is not taxed. Suppose, for example,

you paid \$1,100 in 1951 for a \$1,000 principal-value bond with \$100 in interest past due. In 1952, you received the past-due interest. You need not report this money as interest. It's considered a return of the capital you originally invested.

On the other hand, suppose the \$100 extra price you paid simply reflects an increase in the bond's value. In that case, the \$100 can be amortized over the remaining life of the bond. If, for instance, it matures in 1962, you can write off \$10 a year. And if the bond pays, say, \$50 a year (5 per cent) interest, your net taxable interest becomes, in effect, \$40.

One word of caution before citing the next rule: Go slow in accepting advance payment of interest. If you take payment now of mortgage interest due in 1954, the resultant bulge in your income may put you in a higher tax bracket. Only if you're pretty certain that your 1954 income will be sharply higher should

By John C. Post



and greater convenience IN **CONSTIPATION** MANAGEMENT

With Mucilose Compound Tablets the initial dose required is only 2 tablets after each meal always taken with 2 glassfuls of water. This may usually be reduced after three or four days. Mucilose Compound Tablets are convenient to carry and easy to swallow.

For greater effectiveness Mucilose Compound Tablets combine tried and proved Mucilose (purified hemicellulose from psyllium seed) with the widely accepted synthetic colloid, methylcellulose (75 per cent). This combination assures a maximum amount of bulk...the formation of a smooth, lubricating, water-retaining mass to induce normal peristalsis and elimination of soft, demulcent stools.

MUCILOSE[®] COMPOUND TABLETS

for "physiologic elimination"

HOW SUPPLIED

MUCILOSE COMPOUND TABLETS—bottles of 100 and 500.

also

MUCILOSE ALKALINE CONCENTRATE—bottles of 4 oz. and 1 lb.
MUCILOSE ALKALINE SYPHON—bottles of 4 oz. and 1 lb.
MUCILOSE SWEETENED SYPHON—bottles of 4 oz. and 1 lb.
MUCILOSE WITH CITRIC ACID—0.5 gram per heaping teaspoonful, bottles of 4 oz.

WINTHROP-STEARNS INC.

NEW YORK 17, N. Y. • CHICAGO, ILL.

Product of Wintthrop-Stearns Inc., N. Y. N. Y.

you accept any interest in advance.

A somewhat similar problem arises with U.S. savings and war bonds (Series A-F). These mount in value each year as they approach maturity; and, in reporting the accrual of interest on them, you have a choice: You can pay tax annually on the increase; or you can wait until maturity to pay on the lump sum. Just remember that once you elect to declare the appreciation annually, you can't change without permission from the Commissioner of Internal Revenue.

State and City Bonds

Rule: You need not pay taxes on interest derived from bonds issued by a state, territory, county, city, town, or school district, or by certain public authorities. Also tax-free is interest on postal savings deposits made, and on Federal bonds issued, before March 1, 1941.

Exception: You pay a surtax (but not the normal tax) on any interest that you get from the above Federal bonds you own in excess of \$5,000 principal value. (To qualify for this partial exemption, you must of course itemize all deductions on your tax return.)

If you own more than \$5,000 worth of such bonds, then, make a study of them now. Since some pay higher rates than others, you'll want to include the better-paying ones in the \$5,000 exemption. Suppose, for instance, you have \$5,000 in each of two issues—one paying 3 per cent, the other 2 per cent. If you claim the

former as exempt, you'll save all taxes on \$150, rather than on only \$100.

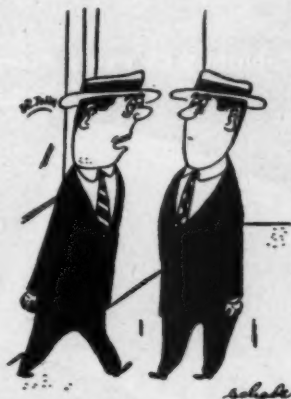
Deducting Payments

Rule: You can deduct all interest payments on your *professional* obligations. These should be entered, in your return, on Line 13 of Schedule C. Included among them (but *only* when you've incurred the debt in connection with your practice) are interest payments on the following:

¶ Loans—from bank, individual, or finance company.

¶ Mortgages on property you own or are liable for. (In the case of a home-office, you of course allocate your interest payments between professional and personal expenses according to the relative amount of floor space you use for your practice.)

[MORE→]



"Yeah, he seemed to know what I have. He asked for five dollars; I had six."

HIGHEST CURE-RATE
REPORTED*

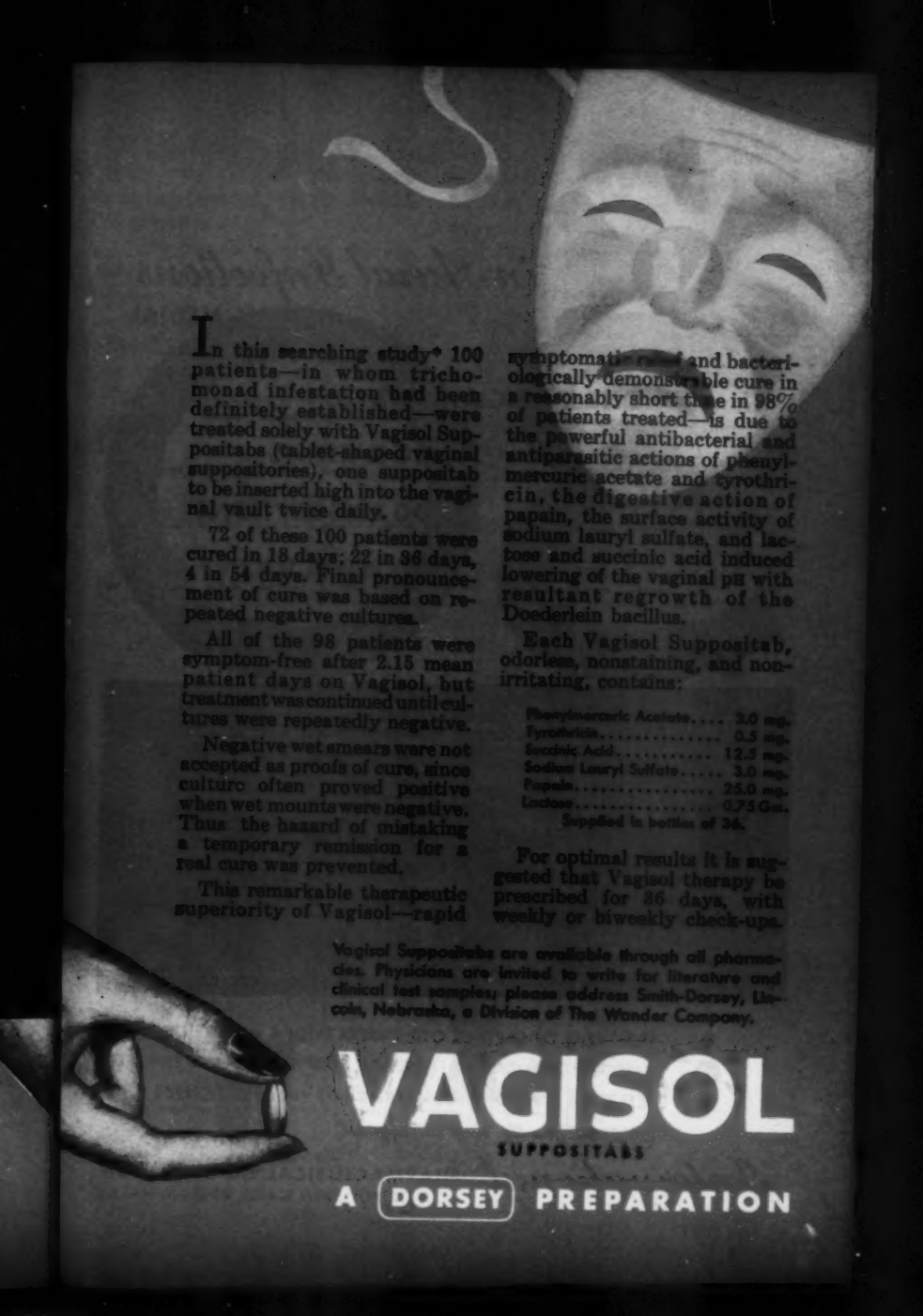
98%

*In Trichomonas Vaginalis
Vaginitis*

established by every accepted laboratory procedure,
including parasitologic cultures



Shaw, H. N.; Henriksen, E.; Kamel,
J. F., and Thompson, C. F.: Clinical and
Laboratory Evaluation of "Vagisol" in
the Treatment of Trichomonas Vaginalis
Vaginitis, *Western J. of Surg., Obst. &
Gynec.* 69:11 (Nov.) 1962.



In this searching study* 100 patients—in whom trichomonad infestation had been definitely established—were treated solely with Vagisol Suppositabs (tablet-shaped vaginal suppositories). One suppositab to be inserted high into the vaginal vault twice daily.

72 of these 100 patients were cured in 18 days; 22 in 36 days, 4 in 54 days. Final pronouncement of cure was based on repeated negative cultures.

All of the 98 patients were symptom-free after 2.15 mean patient days on Vagisol, but treatment was continued until cultures were repeatedly negative.

Negative wet smears were not accepted as proofs of cure, since culture often proved positive when wet mounts were negative. Thus the hazard of mistaking a temporary remission for a real cure was prevented.

This remarkable therapeutic superiority of Vagisol—rapid

symptomatic and bacteriologically demonstrable cure in a reasonably short time in 98% of patients treated—is due to the powerful antibacterial and antiparasitic actions of phenylmercuric acetate and tyrothricin, the digestive action of papain, the surface activity of sodium lauryl sulfate, and lactose and succinic acid induced lowering of the vaginal pH with resultant regrowth of the Doederlein bacillus.

Each Vagisol Suppositab, odorless, nonstaining, and nonirritating, contains:

Phenylmercuric Acetate.....	3.0 mg.
Tyrothricin.....	0.5 mg.
Succinic Acid.....	12.5 mg.
Sodium Lauryl Sulfate.....	3.0 mg.
Papain.....	25.0 mg.
Lactose.....	0.75 Gm.

Supplied in bottles of 36.

For optimal results it is suggested that Vagisol therapy be prescribed for 36 days, with weekly or biweekly check-ups.

Vagisol Suppositabs are available through all pharmacies. Physicians are invited to write for literature and clinical test samples; please address Smith-Dorsey, Lincoln, Nebraska, a Division of The Wander Company.

VAGISOL

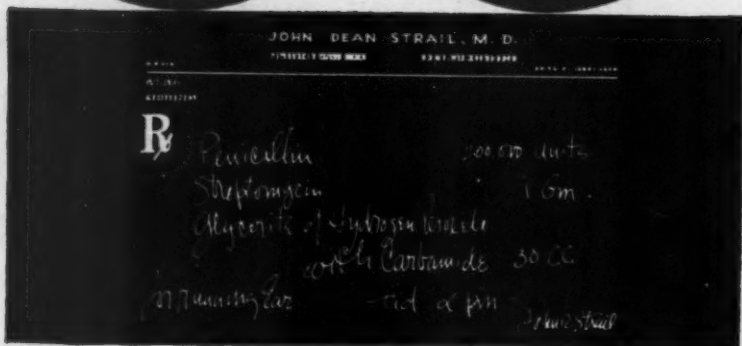
SUPPOSITABS

A **DORSEY** PREPARATION



in Aural Infections
(OTITIS MEDIA)

30
ONE PHYSICIAN TREATED
30 PATIENTS
30 PRESCRIPTIONS
30 PERFECTLY DRY EARS



TREATMENT OF CHRONIC OTITIS MEDIA WITH A MIXTURE OF
GLYCERITE OF HYDROGEN PEROXIDE, STREPTOMYCIN AND PENICILLIN
A.M.A. ARCHIVES OF OTOLARYNGOLOGY Vol. 53 P. 87, 1951

Reprint gladly sent on request.

International PHARMACEUTICAL CORPORATION
1112 BOYLSTON STREET, BOSTON, MASS.

¶ Installment purchases—if the interest amount is stated clearly in the purchase contract or in the schedule of payments.

¶ Discounted notes, in the year when you've repaid the full face amount.

¶ Margin accounts—if the interest is paid in cash or taken out of dividends collected for you by a broker.

¶ Life insurance loans—if the interest is paid in directly to the lender.

¶ Family loans—when they're bona fide business propositions.

¶ Delinquent taxes—but *not* the taxes themselves.

Interest you pay before it's due is also deductible, provided it's accepted by the creditor and would be deductible if paid on the due date. Thus, if the bank that holds

the mortgage on your office building was willing to take the interest for both 1952 and 1953 last year, you can deduct the total amount on your 1952 return.

Personal Debts

Rule: You can deduct interest you've paid on *personal* debts or transactions, provided you itemize all deductions on page 3 of your tax return instead of taking the standard deduction.

Exception: Interest payments you've made on other people's notes, mortgages, and similar obligations for which you have no legal liability are not deductible. If, for example, you pay the mortgage interest on the home your parents own, to save them from foreclosure, you may not deduct it.

END



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Mr. Weeder is a Nico-Feeder

ALONG with new eating habits, his menu might include DAYALETS, Abbott's burpless multivitamins. Synthetic vitamin A means no fish-oil odor, taste or aftertaste, no allergies due to fish oils. **Patient-pleasing, potent.** Each DAYALET tablet represents 10,000 units of vitamin A, 1000 units of D, 5 mg. of B₁, 5 mg. of B₂, 25 mg. nicotinamide, 1.5 mg. pyridoxine hydrochloride, 1 mcg. B₁₂, 5 mg. pantothenic acid and 100 mg. of C. Sugar-coated, too.

Abbott

Dayalets

The Doctor Nobody Likes

*Every town has its rules,
and the M.D. who flouts
them is in for trouble*

• When a competent doctor does poorly in private practice, someone is bound to say that you can never tell when a town will like an M.D. and when it won't.

That's how it was with a bright, young physician I've known for several years. I'll call him Jim Davis. Three years ago, Davis moved to a town of about 20,000 people and established himself in general practice. Things looked promising. He'd been an outstanding medical student; he'd completed a successful internship; he was energetic and ambitious.

But within six months, few people in the town had a good word to say for him. He was, as one local citizen described him later, "the doctor nobody likes."

Yet no one in the community—least of all Davis himself—could explain exactly what caused his unpopularity. To most observers, it seemed just a matter of chance.

It wasn't chance, though, as the doctor eventually discovered. It never is chance. Whether or not a

physician wins the goodwill of his community depends entirely on how he goes about establishing himself. I found this out when I later had an opportunity to piece together several versions of the Davis saga, and to compare it with other doctors' experiences.

There are several basic things a doctor can do to antagonize a town, and Jim Davis was guilty of at least five:

1. *He took no part in community activities.* He scoffed at lodges and service clubs. He was "too busy" for church activities. As a result, he not only missed out on valuable contacts; he antagonized the very people among whom he hoped to build his practice.

2. *He too closely identified himself with one particular social crowd.* This is dangerous if the crowd happens to be an unpopular one. In Jim's case, it was. It consisted of super-sophisticates—the kind of people whom he and his wife preferred, but who were infinitely less numerous than the Rotarians, Lions, and Masons whom they avoided.

3. *He let word get around that he put money first.* He was just a little too eager to collect bills, a little too

By David Rutherford

Upjohn

**cortisone for
inflammation,
neomycin
for infection:**

Each gram contains:

Cortisone Acetate 15 mg.

Neomycin Sulfate 5 mg.
(equivalent to 3.5 mg. neomycin base)

**Available in 1 drachm tubes with
applicator tip**

The Upjohn Company, Kalamazoo, Michigan

Neosone
Trademark
OPHTHALMIC OINTMENT



anxious to charge for every slight service. In his enthusiasm for a high collection percentage, he sacrificed tact and the building of goodwill.

4. *He took much of his own business out of town.* Dr. Davis and his wife could have forestalled trouble, if they'd wanted to, by buying their household furnishings *before* they moved to town. Instead, they waited until they'd been there a few months—and then bought them in New York. The local merchants burned. Some of them even boycotted the doctor in return for his boycott of them.

Who's a Radical?

5. *He disregarded too many community customs.* For example, the Davises gave a Sunday night party—an unprecedented gesture in that town. They stayed away from church, whereas local mores demanded that leading citizens make at least a token appearance from time to time. And in other ways, the doctor flouted the rules. So the local populace soon thought him “radical”—or, at least, “peculiar.”

Fortunately for Davis, he ultimately caught on to what was happening. As any sensible person would, he set about repairing the damage. Today he's much closer to being generally well regarded.

But some physicians never do catch on. They never quite manage to find the “right” location—and they never quite understand why.

Naturally, not every physician who fails to win community support

makes the same mistakes as Jim Davis. Another doctor I know—let's call him Ralph Adams—had a rough time because he went too far in the other direction. Where Davis had held himself aloof from community activities, Adams joined them all.

He Tried Too Hard

This was fine at first. But then a reaction set in. People said the young doctor was “moving in too fast” and “attempting to take over.” By running for various club offices, by too openly seeking the limelight, he made some influential enemies. His practice failed to grow as he'd hoped it would.

After a couple of years, he was called into military service. When he returned to the town, just recently, he didn't try to “move in” as before. He attended meetings, but he avoided stepping on others' toes. He let the honors seek *him* out. Today his practice is thriving, and he's considered a credit to the community.

Drinking Allowed?

Like Ralph Adams, many new doctors subscribe too emphatically to local customs; and this overemphasis sometimes boomerangs.

A young physician of my acquaintance settled in a Southern community where the “drys” were in strict control. Sensing this, he quickly let it be known that he abhorred liquor. Later, though, he found a few congenial souls who liked an occasional cocktail. So he reverted to mild social drinking.

[MORE→]

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of dysmenorrhea...

...estrogen and androgen go together "the plug and socket" to provide a dual approach for maximum efficiency. Many clinicians feel that these two steroids together, as combined in "Premarin" with Methyltestosterone, are more effective than either one alone in producing relief of pain for suppressing ovulation. Similar results have been reported from such therapy.

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"PREMARIN"

with

METHYLTESTOSTERONE

for combined estrogen-androgen therapy

Result: The town's prohibitionists became twice as angry as they would have been if they'd never been led to expect so much of him.

Location Tips

Doctors experienced in coping with local customs lay down these three rules for new physicians:

¶ Locate in a town where you will, generally speaking, be in harmony with existing mores. Otherwise, your battle to keep up appearances will probably prove too much for you.

¶ In your first months in the community, don't proclaim that you're against its customs—but don't knock yourself out rallying to them, either. Give yourself a chance to size things up first.

¶ If you find there are local prejudices you can't stomach, go your own way. But do so quietly and unobtrusively.

Hurt by His Fees

In a small town, in particular, patients have a habit of comparing notes. What the town thinks of a doctor will often depend on how well (or badly) those notes jibe.

Not long ago, a young physician almost ruined his practice by shifting his fees at frequent intervals, raising them considerably for his wealthier patients. Then the word got around—and the prosperous patients began to go elsewhere.

That wasn't all. In comparing notes about him, people found out something else. They heard about a

restaurant cashier who'd had an appointment with the doctor for 2 P.M. At that hour, the wife of a wealthy mill official had turned up without an appointment. The doctor had seen the rich woman immediately and made the other wait.

This story caused some people of average income to desert him, too. Thus he'd managed to offend two classes of people through his tactlessness.

About Social Climbers

It's generally a mistake for a new doctor to identify himself with any social group, whether rich or poor. An experienced physician once told me that the worst error he'd ever committed was a youthful one. "The society page," he said, "showed my wife and me in evening dress at quite a few parties. Pretty soon, my house calls started falling off, and before long I learned why: People who knew I was moving in those circles were ashamed to let me see them in their shabby bedrooms. Well—I quickly learned my lesson."

Too Much Prosperity

Probably no reasonable layman resents the doctor's gradual accumulation of assets. But experienced physicians agree that a sudden or big display of prosperity may well give rise to envy and jealousy in the community.

"In particular, don't flaunt a plushy car," one specialist warns. "In the city, you can get by with it better than in a small town. But

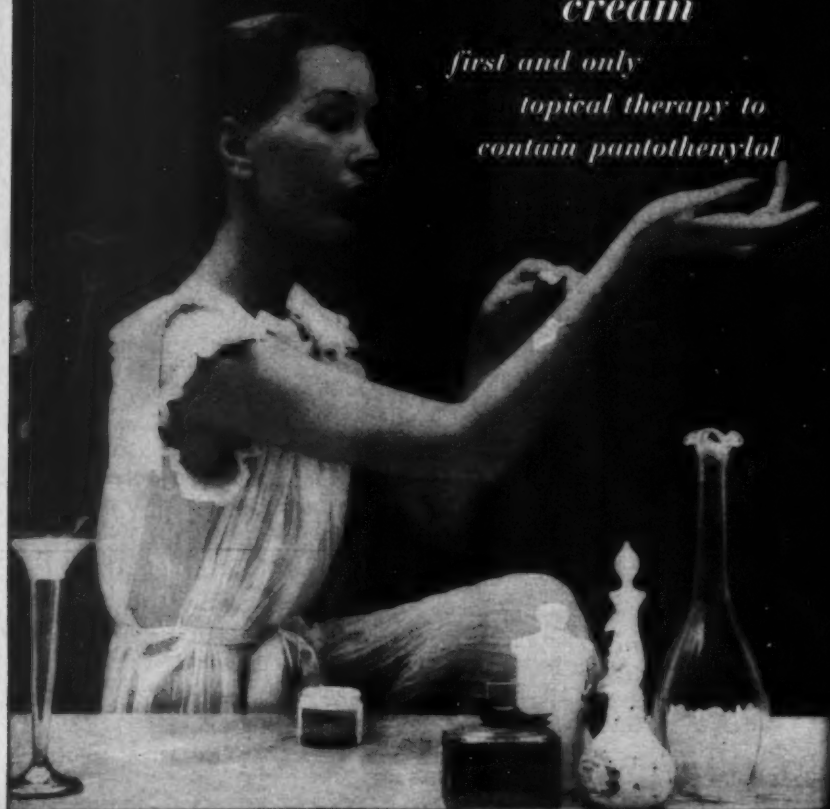
new and
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dermatological disorders ...even those
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even there peoples' prosperity is judged pretty much by their automobiles."

Rx for Doctors

To avoid becoming "the doctor nobody likes," a medical man may well keep these points in mind:

1. A town reacts best to a doctor who moves in easily but unobtrusively. He should take part in community activities, but not too doggedly.

2. A town reacts best to a doctor who neither identifies himself with, nor caters to, any one group.

3. A town reacts best to a doctor who tries to put values into the community as well as to take them out—who patronizes local business, supports local institutions, gives whatever time he can to local causes.

4. A town reacts best to a doctor who fits into the community pattern of living—who attempts, in other words, to understand local customs.

5. A town reacts best to a doctor who gives the impression of being primarily interested in the service he can render. He may have a normal interest in money, but it's a good one for him to soft-pedal. END

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"Cut down on starches; and remember, nothing fried—including you!"



B-D

CLEAR GLASS BARRELS

ASSURE LONGER LIFE FOR YOUR SYRINGES

A unique B-D molding process eliminates the grinding of syringe barrels previously needed to achieve required fit. Clear glass, unground barrels assure:

less friction: The microscopically smooth, unground surface of the clear glass barrel virtually eliminates friction between barrel and plunger.

less erosion: The protective skin of the molded glass barrel remains intact, assuring less erosion during cleaning and sterilization.

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B-D DYNAFIT® Syringes

have clear glass, molded barrels, and are supplied with either LUER-LOK or Luer Metal tips.

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RUTHERFORD, N. J.

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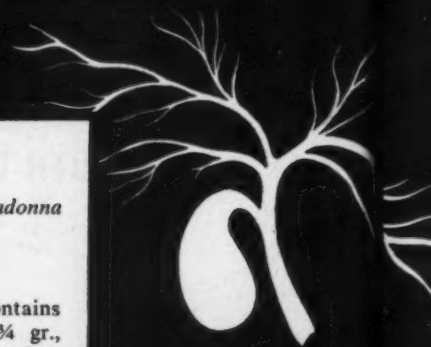
for
reliable spasmolysis
plus
improved liver function

dosage

One or, if necessary, two *Decholin/Belladonna* Tablets three times daily.

composition

Each tablet of *Decholin/Belladonna* contains *Decholin* (dehydrocholic acid, AMES) 3¾ gr., and ext. of belladonna, ⅙ gr. (equivalent to tincture of belladonna, 7 minims). Bottles of 100.



spasmolysis alone is not enough

with **Belladonna**

... for prompt and more effective relief of
belching, bloating, flatulence, nausea,
indigestion and constipation, *Decholin/Belladonna*
provides both:

1. reliable spasmolysis

- inhibits smooth-muscle spasm
- suppresses incoordinate peristalsis
- facilitates biliary and pancreatic drainage

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- increases bile flow and fluidity through *hydrocholeresis*
- enhances blood supply to liver
- provides mild, natural laxation—without catharsis

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47053

A New Catastrophic Coverage Plan

It would be Government-run but wouldn't limit doctors' freedom, claims its backer

● At least one big health-insurance problem has yet to be solved. This is the problem of meeting extra-heavy medical costs.

A few voluntary plans offer so-called catastrophic coverage. But the growth of such plans has been discouragingly slow—so slow, in fact, that there's been increasing talk about the need for Government action.

Naturally, the matter came up for study by the President's Commission on the Health Needs of the Nation. And one scheme for catastrophic coverage was presented to the commission by Harold M. Groves, professor of economics at the University of Wisconsin.

Whether or not the Groves plan is ever put into effect, physicians will want to acquaint themselves with it. So here are its highlights:

Groves' plan is concerned solely with *financing* catastrophic care and not at all with the provision of such care. The scheme would be supported by a 2 per cent Federal tax on personal incomes (presumably,

any portion of a person's income exceeding some set amount would not be taxed). And to cover as many people as possible, it would operate as part of the income-tax machinery.

Like most existing plans for catastrophic coverage, this one would feature a deductible clause; that is, the subscriber would have to pay part of any new medical bill he incurred. Such a clause is essential, the professor says, to keep down costs and prevent abuse.

"The scheme would be between the Government and the taxpayer entirely," he claims. "The doctors could practice and collect precisely as they do at present. Patients would be debited and credited only in their income-tax accounting with the Government."

What percentage of a patient's medical bill would the Government meet? That would depend mainly on the amount of the bill. Uncle Sam would pay a much larger percentage of, say, a \$3,000 medical debt than of a \$300 one.

For a \$4,000-a-year man with medical expenses of \$800, the plan would work something like this:

He'd pay the first \$25 by him-

By Wallace Crootman

No "Belladonna BACKFIRE"



with this prompt, positive relief of **FUNCTIONAL G.I. SPASM**

More and more published clinical studies continue to prove that BENTYL provides effective relief from pain, cramps and general discomfort due to functional G. I. spasm . . . without "belladonna backfire."

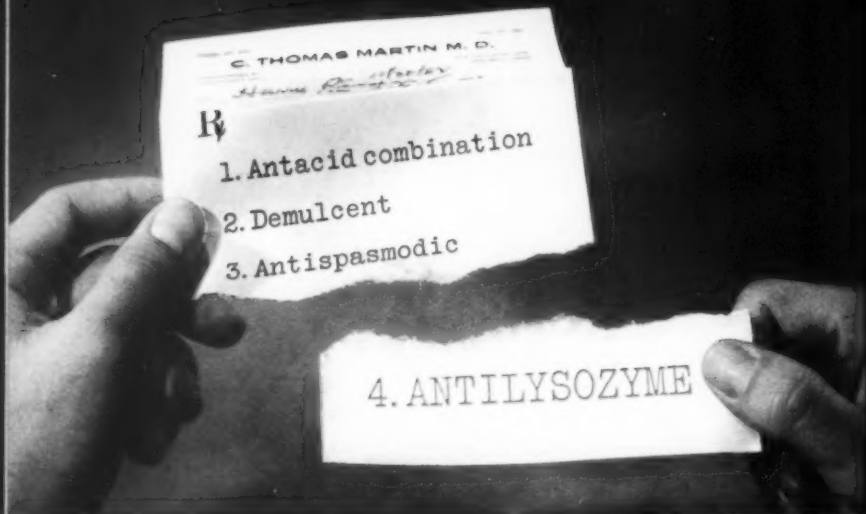


Trade-mark "Bentyl" Hydrochloride

R BENTYL
SAFE, DOUBLE-SPASMOLYSIS

Each capsule or teaspoonful syrup contains
BENTYL.....10 mg.
when sedation is desired
BENTYL.....10 mg.
WITH PHENOBARBITAL.....15 mg.

DOSAGE: *Adults*—2 capsules or 2 teaspoonfuls
syrup 3 times daily, before or after meals. If
necessary repeat dose at bedtime.
In Infant Colic— $\frac{1}{2}$ to 1 teaspoonful syrup 3 times
daily before feeding.



Isn't this too often the missing fourth in *peptic ulcer therapy*?

KOLANTYL INCLUDES THE IMPORTANT 4th FACTOR

1. A SUPERIOR ANTACID COMBINATION (magnesium oxide and aluminum hydroxide, also a specific antipeptic).
2. A SUPERIOR DEMULCENT (methylcellulose, a synthetic mucin).
3. A SUPERIOR ANTISPASMODIC (BENTYL Hydrochloride) which provides direct smooth muscle and parasympathetic depressant qualities without "belladonna backfire."
4. INACTIVATION OF LYSOZYME—Laboratory research and clinical studies^{1,2} indicate that lysozyme plays an important role as one of the etiologic agents of peptic ulcer. By inhibiting or inactivating lysozyme with sodium lauryl sulfate, KOLANTYL includes the important 4th factor toward more complete control of peptic ulcer.

KOLANTYL

DOSAGE: 2 Kolantyl tablets or 2 to 4 teaspoonfuls of Kolantyl Gel every 3 hours as needed for relief.

1. Hufford, A. R., *Rev. of Gastroenterology*, 18:588, 1951
2. Miller, B. N., *J. So. Carolina M. A.*, 48:1, 1952

TRADE-MARKS "KOLANTYL," "BENTYL"



self. But he'd pay only half of the next \$275 and only 30 per cent of the next \$500. His share of the total bill would thus be \$312.50; the Government's share, \$487.50.

An Opening Wedge?

Might adoption of such a program mark the beginning of the end for voluntary health insurance? Professor Groves doesn't think so. He stresses that the Government would not bear the *entire* cost of any sickness. Thus, he believes, people would still want voluntary insurance to cover their share of the risk.

But doctors may not want to go along with this reasoning. They're likely to raise a more basic question:

Might not the Groves plan serve as an opening wedge for full-scale compulsory health insurance?

No matter what the answer, the scheme isn't too different from one proposed three years ago by—of all people—Colorado doctors. And another outspoken foe of socialized medicine, Senator Paul H. Douglas (D., Ill.), has also advocated a form of Government catastrophic coverage.

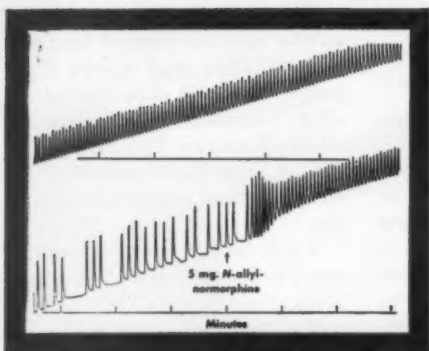
It may be significant that nothing much so far has come of these two plans. Perhaps the Groves scheme will get no further. Yet if it serves no other useful purpose, it should at least prod the voluntary plans into re-examining the problem of very heavy medical costs. **END**



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"Oh, you filled the claim out O.K., doctor. But we don't pay for loss of an arm unless you send the arm in."

A New and Specific Narcotic Antagonist—



*potent and
well-tolerated*

*Effect of NALLINE on
respiratory depression caused by
57 milligrams of morphine.¹*

NALLINE is a specific antidote for poisoning following accidental overdosage with morphine and its derivatives, as well as meperidine and methadone.

This new product, the Merck brand of *N-Allylnormorphine*, rapidly reverses respiratory depression. The respiratory minute volume increases promptly, and the rate increases two- or three-fold.

A recent study² of 270 parturient women indicates the value of NALLINE in obstetrics. Onset of breathing occurred significantly sooner in infants from mothers (sedated with meperidine) who were given NALLINE 10 minutes prior to delivery. *Literature available.*

¹Eckenhoff, J. E., Elder, J. D., and King, B. D., *Am. J. Med. Sci.* 223: 191, February 1952. ²Eckenhoff, J. E., Hoffman, G. L., and Dripps, R. D., Annual Meeting of the American Society of Anesthesiologists, Washington, D. C., Nov. 8, 1951.

SUPPLIED:
Solution of NALLINE Hydrochloride
in 2-cc. ampuls containing 10 mg.
of active ingredient, 5 mg./cc.

NALLINE comes within the scope of the Federal Narcotics Law.

NALLINE

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(N-ALLYLNORMORPHINE HYDROCHLORIDE, MERCK)

*Research and Production
for the Nation's Health*



MERCK & CO., INC.
Manufacturing Chemists
RAHWAY, NEW JERSEY

Why Are Malpractice Rates Soaring?

[CONTINUED FROM 84]

Although there's no real statistical evidence as yet, the board cites this example to back up its contention:

Of twelve potential malpractice cases recently reviewed by one grievance committee, only two finally resulted in suits against the doctors concerned.

Doctors Lose Insurance

In seeking to weed out poor risks, the malpractice board keeps careful tabs on all insured physicians. If it questions a man's "medical procedure, conduct, or attitude," the board calls him in for a hearing. As a result of such hearings, from five to ten physicians are dropped from the group plan each year. (Among those usually given the heave-ho are doctors who act as or employ ghost surgeons.)

If the situation isn't serious enough to warrant dropping a doctor, the board may take one of three other steps:

1. The face amount of his policy may be reduced. When his policy limits are \$5,000/\$15,000, the board reasons, he's less likely to take chances than when his policy limits are \$100,000/\$300,000.

2. A "deductible" clause may be written into his policy. Then, out of

his own pocket, he'd have to pay the first \$1,000 or more of any successful malpractice claim against him.

3. Special protection may be denied him for X-ray therapy, cosmetic plastic surgery, or electroshock therapy.

Rates Fall Behind

What will happen if malpractice costs continue to soar? Despite efforts to reduce claims, the group plan's rates may be boosted still higher—perhaps as much as 50 to 100 per cent higher in the next year or two. Here's why:

Premiums just haven't kept pace with rising malpractice costs. They haven't kept pace because there's a considerable lapse of time before losses can be translated into rate



"Now I know just what you doctors go through to learn your profession. I've just completed two weeks of my first-aid course."

oral diuretic without equal

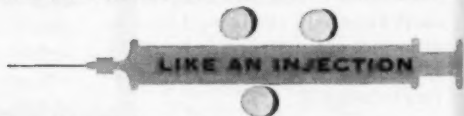
"...superior...in promoting sodium and water excretion."¹

"...three-fourths the diuretic action of the standard [meralluride by injection]..."²

"...a valuable substance to replace parenteral diuretics in patients who require continuous diuretic medication."³

NEOHYDRIN®

THE DIURETIC TABLETS THAT WORK



1. Moyer, J. H., and Handley, C. A.: *Federation Proc.* 11:378, 1952.

2. Greiner, T.; Gold, H.; Warshaw, L.; Palumbo, F.; Weaver, J.; Mathes, S., and Marsh, R.: *Federation Proc.* 11:352, 1952.

3. Goldman, B. R., and Steigmann, F.: *J. Lab. & Clin. Med.* 40:803, 1952.

how to use this new drug

Maintenance of the edema-free state has been accomplished with as little as one or two NEOHYDRIN Tablets a day. Often this dosage of NEOHYDRIN will obtain per week an effect comparable to a weekly injection of MERCUHYDRIN.® When more intensive therapy is required one or two tablets three times daily may be prescribed as determined by the physician.

Gradual attainment of intensive therapy is recommended to preclude gastrointestinal upset which may occur in occasional patients with immediate high dosage. In rare instances a sensitivity to NEOHYDRIN may arise. Though sustained, the onset of NEOHYDRIN diuresis is gradual. Injections of MERCUHYDRIN will be initially necessary in acute severe decompensation.

Contraindicated in acute nephritis and nephrosclerosis.

Any patient receiving a diuretic should ingest daily a glass of orange juice or other supplementary source of potassium. Any patient receiving a diuretic should be watched for signs of depletion in sodium and chlorides especially in hot weather. Such depletion may first manifest itself as a refractivity to the diuretic and can be corrected by ingestion of sodium chloride.

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Bottles of 50 tablets.
There are 18.3 mg. of
3-chloromercuri-2-
methoxy-propyl-
urea in each tablet.



MILWAUKEE 1, WISCONSIN

changes. This problem is peculiar to the malpractice insurance field.

In automobile liability insurance, for example, many claims are reported during the same year the accident happens. But in malpractice insurance, most claims having their origins in a particular policy year aren't reported until two to five years later. What's more, they aren't settled for another three to four years. Thus, five to nine years may go by before it's known whether rates for a given year were adequate.

Of the cases filed in 1951 against members of the New York plan, for example, thirteen were for acts committed before 1947; three were for acts committed as far back as 1941.

Because of this lag, current rates are based largely on *estimated* losses.

If *actual* losses are on the increase, the estimates will be too low and the current rate deficient.

Tough on Carriers

According to the New York malpractice board, its estimates have almost always turned out to be less than actual losses. As a result, the plan's insurance carrier has had to make up the difference out of its earnings on other business.

The same thing has apparently happened to many insurance companies, causing them to write policies sparingly or even to stop writing them. For that reason, the malpractice board in New York is determined to keep its rates in step with losses—even if this means much heavier increases. END

Cold Feet

● The oldster had suffered a foot injury, but it was nothing compared with the injury to my nostrils when I removed his shoes. With all the delicacy I could muster, I asked if the old fellow ever took time out to wash his feet.

"No," he said, "I never put 'em in water."

"You don't like getting them wet?" I asked.

"No it's not that. The *doctor* tole me never to put 'em in water."

Baffled, I asked, "How did that happen?"

"Well, you see, I'd froze my feet, and my folks was just going to put 'em in some warm water; but the doctor said, real emphatic, 'Don't ever do that to feet like that.'"

"How long ago was that?"

"Oh, that was when I was a boy."

Fifty years late, I prescribed warm water—and soap.

—M. B. DURFEE, M.D.

Doctor, shouldn't NYLON elastic stockings give correct SUPPORT too?

Bauer & Black Nylons are more than just beautiful, they're fashioned to exert correct remedial pressure at every point

Your female patients quite naturally prefer elastic stockings in the attractive new nylon. But to be sure your patients get nylon elastic stockings *fashioned* for correct support, we suggest you prescribe Bauer & Black by name. Contour fashioning in two-way-stretch elastic provides properly decreasing pressure up the leg, thereby aiding venous flow. Open toe avoids cramping and constriction in the foot.

In tests, Bauer & Black Nylon Elastic Stockings provided remedial pressures varying *less than 2%* from ideal normal tensions. Here is effective support in stockings that are sheer, inconspicuous and non-discoloring in the new, lighter shade. What better, more acceptable support could you prescribe for surface varicose veins?

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Compare These Support Features

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Knitted with rear fashioning seam so that pressure is adjusted to leg contours. Pressure decreases gradually from ankle up.



ORDINARY TUBULAR STOCKING

Circular knit without seam results in too much or too little pressure at stockings do not fit leg contours.



(Shaded areas indicate points of greatest pressure)

Highlights From the Magnuson Report

Here's what the Truman-appointed Health Commission has to say about individual and group responsibility, the supply of physicians, the organization of medical services, the best ways to pay for them

● The individual effort of an informed person will do more for his health and that of his family than all the things that can be done for them . . . It is the individual who must consult his physician for early care, avoid obesity and alcoholism, and drive his automobile safely. These things cannot be done for him . . .

[But] for most of those who now lack comprehensive health services, the reason lies in large measure beyond individual control. The individual may not be sufficiently well informed to appreciate the benefit and hence does not actively demand it. In many other instances, the medical personnel and facilities do not exist in the area in which he lives. Moreover, an individual may be fully convinced of the primary value of the best health service . . . yet not have available the money to purchase it . . .

Hence, the community—and particularly the most responsible community organization, government—must participate in the expansion of means to achieve health . . .

The Federal Role

The Federal Government . . . must provide leadership and initiative in blueprinting the building up of our health resources. Of particular importance is [its] obligation . . . to equalize the opportunities for health among the citizens of the various states through use of the Federal taxing power to overcome the disadvantages of low-income states. Grants-in-aid . . . should continue as an important form of national assistance . . .

The Doctor Supply

The physician is the key to the provision of modern medicine. We

**These excerpts are taken directly from the final report of the President's Commission on Health Needs,*

previewed in our December issue. For editorial comment, see page 65, this issue.

Why

Instant Ralston



**is so good during
pregnancy and lactation**

**Whole Wheat, with 5% Extra Wheat Germ
Twice as Much as in Natural Whole Wheat**

EXTRA-NUTRITIOUS

Contains *all* nutrients of whole wheat plus *all* those of the extra wheat germ.

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So appetizing reducers enjoy it *without* "fattening" spreads.

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All the protein, minerals, B-vitamins of whole-grain rye.

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Absorbs moisture which increases bulk, delays hunger.

There is only ONE Ry-Krisp

Tell your patients to look for the name "Ry-Krisp" on the package and on each wafer.

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With other B-Complex Factors from Liver	

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Preparation

J. B. ROERIG AND COMPANY, 336 LAKE SHORE DRIVE, CHICAGO 19, ILL.

found insistent indication of a shortage of physicians.

There are not enough general physicians, and most of those we have are so busy that they cannot give the patient the time and sympathetic care the old family doctor could give in a home visit.

We need more pediatricians to assure children the optimum health protection that is their due. Our mental and tuberculosis hospitals are critically short of staff . . . In fact, with the possible exception of surgery, there seems to be no area of specialization in which the supply of physicians meets even the present demand . . .

Why Not Redistribute?

It has been suggested by some that the physician shortage is largely a matter of distribution, that it can be solved, for example, by transplanting physicians from well-doctored Manhattan to under-doctored Mississippi. This proposal overlooks a number of important facts.

First, our society is not one in which people can be moved about without regard to their own wishes.

Second, even in the areas with a relatively better supply of physicians, numerous vacancies exist. For example, in the New England and Middle Atlantic states, the growing fields of public health, industrial medicine, and rehabilitation—as well as mental and tuberculosis hospitals, medical schools, and research organizations—are actively seeking physician personnel.

Third, we have received impressive evidence of the fact that medical students, upon completion of their training, tend to return to the area and kind of community in which they were brought up.

Fourth, it is our carefully weighed conclusion that the growth of prepayment plans and the extension of preventive medicine will increase the demand for physicians to a point higher than the present or predicted total supply, even if an ideal distribution were possible . . .

Medical School Support

A number of studies conducted over the past few years have found the medical schools need from 10 to 40 million dollars in increased operating revenue each year, and a minimum of several hundred million dollars for new construction and capital expansion. Although such private efforts as that of the National Fund for Medical Education and the American Medical Educational Foundation are to be heartily commended, there is serious doubt to whether they will be able to raise the big sums needed . . .

We wish to note here the favorable experience of the medical schools in relation to grants provided through the U.S. Public Health Service and other Federal agencies for research, construction, teaching, fellowships, and training. Over the past few years, these have amounted to many millions of dollars. Yet we heard only praise for the manner in which these grants are administered,

and we note the absence of any encroachments upon academic freedom in these programs . . .

Federal Funds Urged

To overcome the present financial crisis in our institutions for the education of health personnel, [we recommend that] Federal funds be made available:

¶ To schools of medicine, dentistry, nursing, and public health for modernizing and expanding their physical facilities.

¶ To these same schools to make up operating deficits; these operating funds to be used, wherever consistent with the highest quality of education, for a gradual, carefully planned expansion of enrollment without discrimination on account of race, creed, or geographical residence.

¶ To encourage the development of new medical, dental, and public health schools, and collegiate schools of nursing in those areas of the country which are now in need of such schools . . .

[And] to remove the economic barriers which now restrict the freedom of American youth in gaining entrance to the health professions . . . [we also recommend] that Federal funds be made available:

¶ For scholarships to students who could not otherwise afford to attend school for education and training in the health professions . . .

Disorganized Medicine

The genius for organization, so characteristic of American life in general, is conspicuous in health services by its absence. By organization is meant the process of putting together people and facilities and utilizing them in the most efficient manner.

In industry, the application of this principle has made possible our enormous productivity and our high standard of living. By contrast, the lack of organization that prevails in medical practice is the despair of the industrialist and the labor leader.

This has come about quite naturally. The intimate personal relationship of physician to patient cannot be replaced by production-line methods . . . The intense individualism of the average physician fits him very poorly for the place of a cog in any machine. But the increased complexity of health service . . .



"Buck up, Smedley, there's always tree surgery."

*Controls Useless
Nagging Cough*

Syrup 'Histadyl E.C.'^o is an effective combination of:

Codeine Phosphate (1 gr. per fl. oz.)
a bronchial sedative

Ephedrine Hydrochloride (1/2 gr. per fl. oz.)
a bronchodilator

Thenylpyramine Fumarate (1 1/3 grs. per fl. oz.)
an antiallergic

and Ammonium Chloride (10 grs. per fl. oz.)
an expectorant

in a pleasantly flavored syrup acceptable to both children and adults. It is available on prescription at pharmacies everywhere.

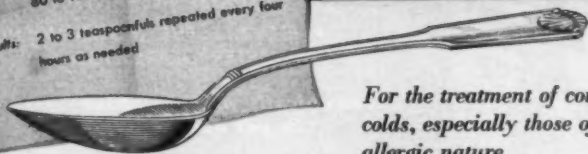
^oFederal record of sale required.

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DOSAGE

Children: 30 to 50 pounds, 1/2 to 1 teaspoonful
50 to 80 pounds, 1 to 1 1/2 teaspoonfuls
80 to 100 pounds, 1 1/2 to 2 teaspoonfuls

Adults: 2 to 3 teaspoonfuls repeated every four hours as needed



*For the treatment of coughs and
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Especially valuable for
Geriatric patients and
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FELLOWS Syrup will

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makes it increasingly apparent that some order must be achieved . . .

Five Main Flaws

As organizational deficiencies in our present health service's, one might cite:

1. Isolation of the small community and rural hospitals—their patients and their staff members—from the mainstream of fast-moving medical developments in urban medical centers.

2. Isolation of the urban medical centers—their staffs and, perhaps even more important, their students—from the everyday practice and problems of medical care.

3. Failure to utilize wisely and fully the time of professional health personnel. For example, physicians, dentists, and professionally-trained nurses are engaged too often in tasks which could be performed as well or better by less highly trained personnel. Another example is the wasted time and talent of the young, well-trained physician or surgeon during the years he is "establishing himself in practice."

4. Inefficiency because of the lack of proper utilization of laboratory, X-ray, and other diagnostic and therapeutic equipment . . .

5. Sketchy public health services, inadequate in population coverage . . . and isolated from hospital and other . . . health services . . .

Rural Recommendations

A great difficulty is the vicious circle in which all too many rural

people in thinly settled areas get caught: They cannot get physicians because there are no hospitals and [they] cannot get hospitals because there are no physicians and maybe [they] cannot get either because of low per capita wealth or income . . .

We therefore recommend that . . .

¶ Emphasis be placed upon establishing good working relationships between small rural hospitals and larger medical centers . . .

¶ General physicians in rural areas establish group practice arrangements, if necessary with specialists in nearby urban areas . . .

Rx for Specialists

What should be done to utilize the services of the specialist to better advantage, to extend his skills to rural regions as well as metropolitan centers, and to coordinate his activ-



Kymographic recording shows normal contraction of rabbit jejunum in 100 cc. of Tyrode's solution.

When the EMETROL solution is replaced with fresh Tyrode's solution, normal contraction resumes.

Adding 0.5 cc. of EMETROL immediately relaxes the muscle... reduces rate and amplitude of contraction.

With 1.0 cc. of EMETROL, these effects become much more marked.

this is why **EMETROL** controls e

(PHOSPHORATED CARBOHYDRATE SOLUTION)

EMETROL Phosphorated Carbohydrate Solution permits effective physiologic control of functional nausea and vomiting—without recourse to antihistaminics, sedatives, or hypnotic drugs.

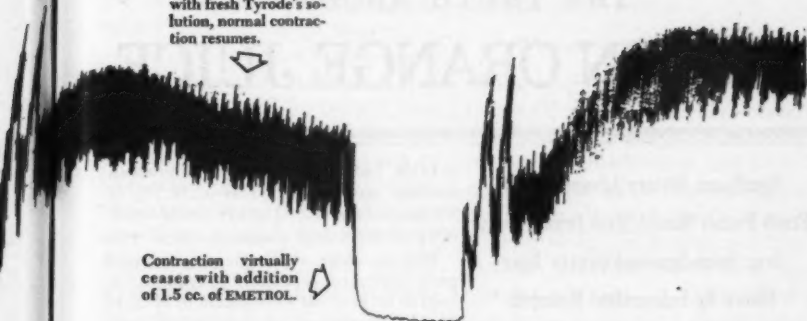
Pleasantly mint flavored, EMETROL provides balanced amounts of levulose and dextrose in coacting association with orthophosphoric acid, stabilized at an optimal, physio-

Kinney

SAMPLE AND LITERATURE

When the EMETROL solution is replaced with fresh Tyrode's solution, normal contraction resumes.

Contraction virtually ceases with addition of 1.5 cc. of EMETROL.



ols epidemic vomiting physiologically

logically adjusted pH level.

Thus, EMETROL can be given *safely*—by teaspoonfuls for children, tablespoonfuls for adults—at *repeated* intervals until vomiting ceases.

IMPORTANT: EMETROL is always given *undiluted*. No fluids of any kind should be taken for *at least 15 minutes* after taking EMETROL.

INDICATIONS: Nausea and vomiting resulting from functional disturbances, acute infectious gastroenteritis or intestinal "flu," pregnancy, motion sickness, and administration of drugs or anesthesia.

SUPPLIED: Bottles of 3 fl.oz. and 16 fl.oz., at all pharmacies.

KINNEY & COMPANY
COLUMBUS, INDIANA

TO PHYSICIANS ON REQUEST

THE TRUTH ABOUT FROZEN ORANGE JUICE

Significant Dietary Advantages Of Fresh-Frozen Minute Maid Orange Juice Over Home-Squeezed Orange Juice Shown By Independent Research

RECENT assays¹ emphasize the nutritional superiority of reconstituted Minute Maid Fresh-Frozen Orange Juice over home-squeezed orange juice in three respects:

- a. Average levels of natural ascorbic acid were significantly *higher* in Minute Maid;
- b. Peel oil content was significantly *lower*;
- c. Bacterial counts were dramatically *lower*.

Two reasons for Minute Maid's higher ascorbic acid content are advanced:

First, oranges vary widely in ascorbic acid content.² Thus, whole oranges squeezed a few at a time provide a highly erratic source of Vitamin C. Each can of Minute Maid, however, represents the pooling of juice from hundreds of thousands of oranges; thus wide variations in nutrients tend to be eliminated.

Second, because it is frozen, Minute Maid loses none of its ascorbic acid content before reaching the consumer.³ Whole fruit, however, is subjected to variations in temperature, and care in handling cannot be maintained from tree

to table. Laboratory tests have shown an average ascorbic acid loss of 10.7% in whole oranges after 11 days under simulated storage and shipping conditions.

Peel oil, cause of allergic response and poor tolerance, especially in infants,⁴ is held to an arbitrary minimum in Minute Maid. Samples of home-squeezed juice expressed by typical housewives showed peel oil contents up to 700% higher.

Bacterial counts were found to be as high as 350,000 per ml. in home-squeezed samples—but were uniformly low in Minute Maid. Technicians ascribe this to the combination of rigid sanitary controls in the Minute Maid process and the low pH and low temperatures at which the juice is kept. High bacterial counts in home-squeezed juice are doubtless due to contamination from the exterior peel which is unknowingly added to the juice during preparation.

In view of the above findings, more and more physicians now specify Minute Maid Fresh-Frozen Orange Juice in lieu of home-squeezed orange juice.

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MINUTE MAID CORPORATION, 488 Madison Ave., New York 22, N. Y.

Wallace R. Roy, Ph.D., Director of Research

ities with those of other health personnel? The widespread organization of group practice units appears to be a large part of the answer.

The group practice of medicine is a characteristically American response to the need for organization of health services . . . More than 600 medical groups are now known to be functioning in the United States. More than half the physicians in military service during World War II signified their desire to join groups upon return to civilian life. Over-all, the movement toward this form of practice is growing fairly rapidly . . .

Multiple Screening Backed

In the immediate future, great reduction of the burden of chronic diseases can be expected from early detection and adequate treatment . . . The ideal way to achieve this would be for every person to have a thorough annual medical examination. But, actually, there are not enough physicians in the United States to give such examinations to 150 million people and also take care of the sick.

There is, however, a practical way to accomplish a large part of this purpose—multiple screening. This means the application of a battery of economical, rapidly applied tests to screen out apparently well persons who probably have a disease from those who probably do not. Those who are found with “positive” tests are referred to physicians for follow-up diagnosis and treatment. The . . . facts support the extension

of multiple screening, not only in physicians’ offices but also in hospitals and health centers . . .

Tomorrow’s Hospital

The hospital of tomorrow should be a well-rounded health center from which preventive, diagnostic, treatment, rehabilitative, and home-care services radiate to the entire community. It should be the center of the physician’s professional life, providing laboratory and X-ray facilities for his use . . . Every physician in the community should have some affiliation with a hospital . . .

The out-patient unit of a hospital should be the focus of health services which promote health. Ideally, it should supervise the health of the well child, advise the mother during pregnancy, supply laboratory services for ambulatory patients of the physicians in the community, [and] run health-education classes . . .

The Dollar Barrier

There is no way to arrive at a precise estimate of the magnitude of the financial problem . . . However, the individual often does not obtain health services when the need arises because he simply does not have the money to pay for them. The bald fact that 48 per cent of our families receive \$3,000 or less annual income is proof of this.

The number of patients who daily receive part or all of their medical care through charity or public assistance is . . . by no means a full measure of the problem. There are many



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EVERY VIM SYRINGE IS:

- Precision ground, fitted and tested to guarantee smooth-as-silk action with minimum back-fire.
- Triple annealed to minimize breakage in sterilization.
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EVERY VIM DURA-SHARP stainless steel needle is rigidly inspected to insure perfect uniformity. They keep their keen sharp cutting edge, the chrome plated hub fits all U. S. standard syringes. Available at your surgical supply dealers

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more who get no care or inadequate care when they need it . . .

About Prepayment

We believe that the correctness of the prepayment principle has been demonstrated by the private plans presently in operation, but that they have not yet proven their ability to meet adequately the need for prepaid personal health services.

They do not for the most part offer comprehensive service, but limit their benefits to hospital and surgical care. Many of them offer only cash indemnity for medical expense, a method of compensation which often does not cover the full charge and which lends itself to a variety of abuses. They often exclude pre-existing conditions needing care and are not available to many population groups. Their control is usually such as to preclude consumer representation in policy-making and they require a flat premium rate, irrespective of income . . .

Recommended Yardsticks

The extent to which the private prepayment plans meet the needs of the people should be reviewed critically, and they should be judged by the extent to which they:

¶ Provide protection against the total cost of personal health services, including preventive services, diagnosis, treatment, and rehabilitation, outside the hospital as well as in the hospital—except prolonged hospitalization for mental disease, tuberculosis, and other chronic illness.

¶ Bring prepaid protection to the total gainfully employed population (including workers employed in small groups, the self-employed and rural people) and their dependents.

¶ Provide for services on a basis which assures maximum efficiency and economy in cost of operation and in the methods of payment for services; and on a basis which allows for continued development of medical education and residency training programs.

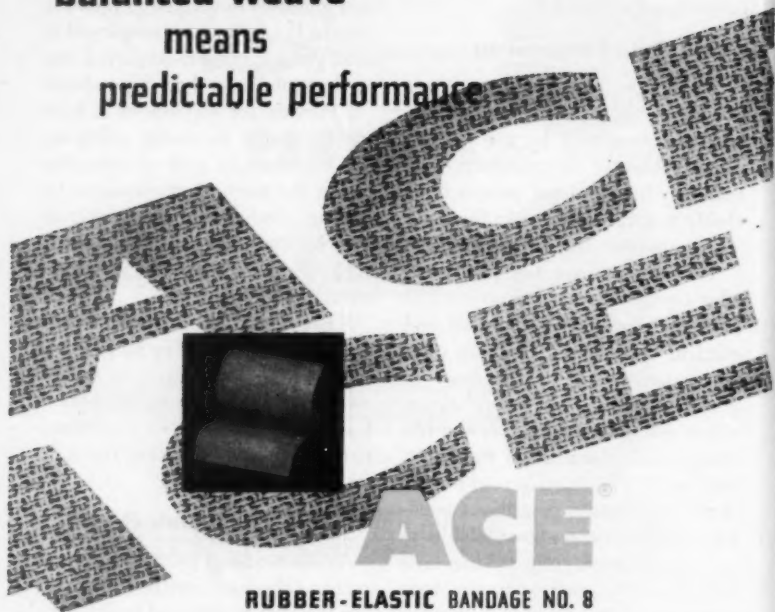
¶ Recognize their responsibility to the public interest by inclusion of consumer representatives on the decision-making boards in numbers at least equal to that given representatives of groups providing the services . . .

If They Can't Pay

While we have proposed prepayment as the basic method for meeting the cost of personal health services, it must be recognized that . . . certain groups [lack] the means to purchase such protection.

These include families receiving public assistance to meet the costs of food, clothing, or shelter—either general public assistance alone, or benefits to which the Federal Government contributes, such as those for the blind, the aged, dependent children, and the permanently and totally disabled. Another group consists of those older persons now subsisting largely on Old Age and Survivors Insurance benefits, which amount to about \$42 monthly on the average . . . [MORE→]

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means
predictable performance**



RUBBER-ELASTIC BANDAGE NO. 8

B-D research in weaving processes assures the proper proportion of best quality, long staple cotton and latex yarn. This "balance-in-weaving" produces a bandage of uniform stretch and body. When you apply the famous **ACE** Rubber-Elastic Bandage, you know it will provide optimal therapeutic benefits for your patients.

In a wide variety of conditions requiring extra compression or support, **ACE** Rubber-Elastic Bandage No. 8 provides these exclusive **ACE** features:

balanced weave provides optimal support with uniform tension throughout the afflicted area

built-in elasticity minimizes slipping or loosening of the bandage

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B-D

If all our people are to receive high quality personal health services, Government must develop a suitable mechanism, at least for those with low incomes, and finance it—wholly for some, and probably in part for others. This mechanism should embody the cooperative effort of local, state, and Federal government, and non-governmental agencies including private hospitals and the health professions . . .

Six-Point Program

We therefore recommend that:

1. The principle of prepaid health services be accepted as the most feasible method of financing the costs of medical care.

2. The present prepayment plans be expanded to provide as much health service to as many people as they can; be judged by the criteria mentioned [above]; and be aided by Government through allowing payroll deductions for governmental employees, releasing the restrictions on organization of prepayment plans, and promoting research on health service administration.

3. A cooperative Federal-state program be established to assist in the financing of personal health services . . . Each state would draw an over-all state plan for assisting the development and distribution of personal health service for all persons, using public or private agencies and resources, or a combination of them . . . State plans would be expected to conform to certain Federal minimum standards . . . Federal

funds for the program might be derived from several different sources, as suggested below.

4. Funds collected through the [Social Security] mechanism be utilized to purchase personal health service benefits on a prepayment basis for beneficiaries of that insurance program, under a plan which meets Federal standards and which does not involve a means test.

5. Federal grants-in-aid be made from general tax revenues for the purpose of assisting the states in making personal health services available to public assistance recipients. This should be done under a prepayment plan which is . . . approved by a Federal health agency in accordance with Federal standards, and which specifies:

¶ A state-wide program administered by a single state agency, with an advisory council representing the public interest.

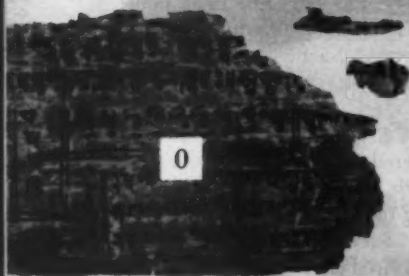
¶ Services to all persons who are declared eligible, with no discrimination as to age, race, citizenship, or place or duration of residence; and with no means test at the time care is needed.

¶ As comprehensive personal health services as local resources permit, with maximum utilization of all available health personnel and facilities.

¶ Administration on a local or regional basis.

6. Federal grants-in-aid be made from general tax revenues for the purpose of assisting the states in making personal health services

Number 2 of a series on the human meaning of great discoveries



THE DIFFICULTY OF KNOWING NOTHING

We may say that early man knew almost nothing. But nothing is just what early man could not know. The knowledge of nothing came hard and late in the progress of civilization. Plato and Aristotle, and even the great mathematician Euclid, calculated without a zero. With all that they knew, they did not know nothing. Bagdad of the Arabian Nights was the birthplace of the zero. The bawling bazaars of a great commercial city demanded swift accurate accounting, and the Arabian mathematician, al-Kwarizmi, met the need. Humanity's long journey out of darkness begins anew for each child opening his eyes to the light, seeking and discovering, finding answers to living needs. Science serves these needs from the moment of birth, even before birth.

General Pharmacal Corporation, Los Angeles, California



General Pharmacal Corporation is the creator of Q-Test, the one-hour office screening test for pregnancy. Sold only to physicians through ethical channels.

available to the general population, under a plan meeting the same criteria as above . . .

About Old Folks

Studies conducted in 1946 and 1949 show for couples past 65 and receiving [Social Security benefits] an average health services bill of \$160 per year. One-fourth of them had medical and hospital bills of more than \$200. Only one-twelfth of the couples having a member hospitalized during the year had any form of hospital or medical care insurance . . . They are considered "bad risks" by insurance organizations and even if eligible the premiums would usually be beyond their means . . .

It is clear that the solution to the problem of payment for health services to the aging lies neither in what may be expected from currently available private insurance programs . . . nor in any reasonably anticipated increase in cash benefits under [Social Security]. Rather, the situation requires a new approach—one supported largely by public funds specifically earmarked for health care . . .

Reply to Critics

None of us had any idea when we started our work that we would run into so many significant areas in which there were demonstrable, well-documented health needs . . . The hundreds of medical and other experts who came to our Washington sessions and the public hearings

around the country presented irrefutable testimony as to the many weaknesses in our health services.

To those who assert that there is no real health problem and therefore no need for this kind of study, we say: The thousands and thousands of pages of testimony which are part of the commission's official record refute that point of view . . .

Congress should establish a permanent Federal Health Commission, composed of from twelve to eighteen members appointed by the President with the approval of the Senate. The term of office should be six years, with one-third of the terms expiring every two years. Not more than half the members should be health professionals, and no member should be an officer or employee of either the Federal or state governments.

END



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Pyridoxine Hydrochloride.....	6 mcg.
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Since many state and local—and even some Federal—taxes you pay can be deducted on your U.S. income tax return, you should know which ones are deductible and which aren't.

Here's a guide

● Most of the taxes you incur in connection with your practice—and some non-practice-connected ones too—are deductible from your Federal income tax. These are important deductions, too; for they may whittle down your tax liability by several hundred dollars a year. Following are lists of the specific taxes you can and cannot deduct.

Deduct These Taxes

¶ Social Security taxes *you* pay for your employees—but not their own contributions that you're required to withhold.

¶ The cost of necessary medical licenses and permits to handle narcotics.

¶ Federal excise taxes on items of professional expense—such as the tax on office telephone service. (To the extent that a telephone is used for personal calls, neither the cost of the service nor the tax is deductible.)

¶ City and state income taxes.

¶ The cost of all automobile and driver's licenses.

¶ Sales taxes on both personal and professional purchases. (Revenue agents don't expect you to keep all sales slips; they'll accept a reasonable figure based on canceled checks and on estimates of your cash transactions.)

¶ State taxes on gasoline used both personally and professionally. (You can compute these from mileage covered. If you drove 7,500 miles in 1952, averaged 15 miles to the gallon, and paid a 5c-a-gallon tax, the total tax paid for the year would be \$25.)

¶ Personal property taxes.

¶ State and local admission taxes; state cigarette taxes in Florida, Maine, New Jersey, and Tennessee (where they're imposed directly on the purchaser); and state stock-transfer taxes.

¶ Real estate taxes on both pro-

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supplies all the vitamins needed in the first months of life—A, C and D—in an aqueous vehicle. Contains only synthetic vitamin components—an excellent dietary supplement for those who cannot tolerate natural source vitamins.

Contains (per 0.6 cc): 5000 U.S.P. units Vitamins A—1000 U.S.P. units

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Bottles of 15 and 50 cc. with calibrated droppers.

Through infancy and childhood

...multiple vitamin potency
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provides balanced amounts of the vitamins necessary to proper nutrition in normal infants, in a stable, water-miscible solution. Contains only synthetic vitamin components. Unusually pleasant tasting when taken directly; does not alter the flavor of foods with which it is mixed.

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1 mg. Thiamine hydrochloride U.S.P.—0.4 mg. Riboflavin

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Immune Serum (Human)

***Goes to work immediately
to prevent mumps and to aid in
preventing mumps complications***

Administered within first 7 days exposure, serum confers passive immunity for approximately 10 to 14 days. In treatment there is some evidence that the serum prevents serious complications if administered early and in adequate amount. (J.A.M.A. 149:1360, Aug. 2, 1952.)

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fessional and non-professional property. (In the case of a home-office, the tax must of course be allocated between professional and personal expenses according to the relative amount of space used for practice.)

Don't Deduct These

1. Federal gift, estate, and income taxes.
2. State inheritance and gift taxes.
3. Assessments for local improvements, such as sewers and paving.
4. The cost of dog and hunting licenses (the bureau views these as registration fees rather than as taxes.)
5. Federal stamp taxes on security transfers. (These must be shown as an expense in figuring gain or loss in a capital transaction.)
6. Federal excise taxes on items that are *not* professional expenses, such as those on amusements, tobacco, transportation, cosmetics, furs, and the like.

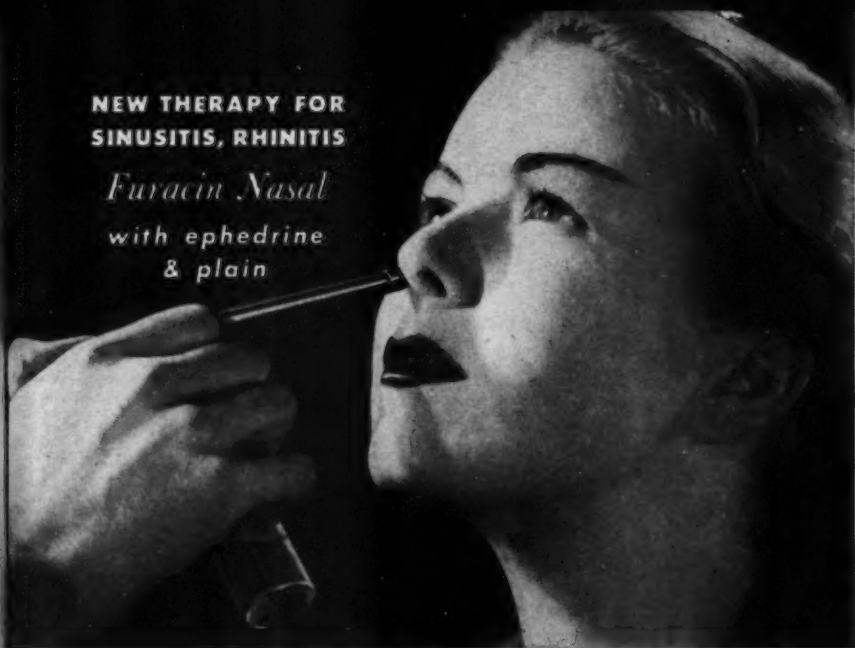
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* Thornell, W. C.: Arch. Otolaryng. 52:96 (July) 1950.

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Literature on request



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What Will This Congress Do for You?

[CONTINUED FROM 69]

ed this proposal, largely out of hostility to Oscar Ewing.

With Ewing gone, this objection has disappeared. The creation of a new department may now command bi-partisan support—especially with Eisenhower's endorsement. The thought of Oveta Hobby in the Cabinet dismays few Congressmen.

Hospitals Unified?

Plans to unify the Government's seven separate hospital systems aren't likely to get far this year, either. There are too many such plans, and they're all competitive and controversial. No one of them is apt to win out in the near future.

Still another medical goal that probably won't be reached is the limiting of veterans' care to service-connected disabilities plus TB and mental disorders. A special committee of the A.M.A. has recommended such limitation; but the veterans organizations are solidly opposed to it. So this, too, is one of the controversial topics that must wait on the projected commission's report.

Tax Relief?

There are non-medical objectives of interest to doctors, too—the Reed-Keogh bill, for example. This would

exempt from taxation limited premium payments to retirement funds of professional associations. The bill is designed to give professional men the tax break they deserve, in consideration of the long periods of training they must undergo before beginning to earn a living.

If the bill should become law, doctors would be able to pay a certain percentage of their annual incomes—taking a tax deduction on the payment—into funds that met Treasury standards. Then, after retirement, they'd receive payments from the fund, paying relatively low tax rates on them.

The proposal will almost certainly be voted—eventually. But tax-writing Congressmen say that 1953 won't be the year. Reason: The Republicans are grimly determined to balance the budget.

The Treasury seems certain to lose large revenues if the excess profits and some individual taxes are allowed to expire. So leaders have decided that further revenue losses



"You have the same thing that my brother-in-law—Heaven rest his soul—had."

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Vitamin A and D Ointment presents the natural A and D vitamins in a pleasantly fragrant lanolin-petrolatum base. It does not stain the skin.

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c September 6. Chronic varicose ulcer in an elderly, obese patient. Therapy with several topical medicaments has produced little or no improvement.

d October 11. After only five weeks of Vitamin A and D Ointment therapy, healing with complete epithelial restoration has occurred, despite the relatively poor vascular supply of the area.

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must be avoided. Besides, it's axiomatic that one tax equalization measure means opening the door to hundreds of others—something Congress wants to duck.

What Doctors Oppose

Measures that most physicians oppose will doubtless have just as tough sledding in the new Congress. But in some of these cases rejection may have the effect of killing, rather than postponing, the proposals.

Take compulsory health insurance, for example. It made an uncomfortable amount of progress under the Democrats. And it may possibly have its day again in the future.

But time is running against it. Already about 60 per cent of the people are enrolled in various types of voluntary prepayment plans. And this Congress is pretty sure to bury compulsion in the most obscure of pigeonholes. So by the time another Democratic Administration takes over, chances are that voluntary programs will have had ample opportunity to get firmly established.

Of course, the Magnuson Commission proposal for Government subsidies to aid local communities in extending prepaid coverage to the indigent may be aired by the Republicans' new commission. But the outlook for its eventual passage is hard to judge. The signs now point to no action in 1953.

A more certain fate can be predicted for the Emergency Maternity and Infant Care (EMIC) program. With dependents already eligible

for allotments and treatment at military posts, "there's simply no need for action," says a top Washington source.

Even the local health unit program may be stymied this year—a victim of the economy drive. The Senate has twice approved legislation for Federal assistance to the states for establishment of full-time, adequately-staffed units in every county. But both times A.M.A. opposition has helped kill it in the House. And now, even though agreement to ban treatment in the centers would probably ease opposition to such legislation, its cost is likely to keep it from going through.

Aid for Schools

On the other hand, proposals for Federal aid to medical education may squeak by. Opposition has been strong, on the ground that annual Government grants constitute a beginning of control; and this is an argument that the Republican leadership would normally buy. But the law-makers are being hard-pressed to do something about the shortage of doctors. The inroads of the doctor draft and the publicity generated by the Magnuson Commission have combined to build up an almost irresistible head of steam.

So, judging by its present temper, Congress will probably approve some kind of bricks-and-mortar program, in which the Government would make grants for construction and equipment of new school buildings—and then withdraw. But out-

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In each Mephate Capsule, 0.25 Gm. mephensin — with 0.30 Gm. glutamic acid hydrochloride.
Adult dosage starts at 2 capsules 3 or 4 times a day, preferably with food or liquids.

*Hermann, L. P., and
Smith, R. T., Jr.,
Lancet 71:271
(July), 1951.

right grants without restrictions—like the \$100-million recommended by the Magnuson Commission—are not likely. And the outlook for Federal scholarships to needy students isn't yet clear.

Social Security?

Congress may actually do something about broadening Social Security this year. But the two proposals of interest to doctors are doubtful prospects for adoption.

One of these would extend coverage to physicians (and men in some other professions, too) on either a compulsory or an optional basis. But the A.M.A. is opposed to either form of coverage. And Congress has adopted the policy of acceding to each profession's wish, as expressed by leading professional societies.

Most doctors oppose compulsory coverage for obvious reasons. But A.M.A. resistance to an optional

plan is based on a feeling that availability of Social Security would weaken the Association's case for the Reed-Keogh bill.

The other Social Security proposal—to waive premiums in cases of total disability—is also apparently doomed. Why, ask many Congressmen, should bureaucrats be permitted to determine who is disabled? Besides, this is a matter for study by Senator Taft's commission—which means, naturally, a long delay.

Extending the Draft

The only piece of legislation that may make many physicians actively unhappy this year is an extension of the doctor draft. Even on this point, though, Congress has no disposition to ram anything down medicine's throat. The feeling is that, before the current law expires on June 30, some kind of "acceptable" extension will be devised. [MORE→

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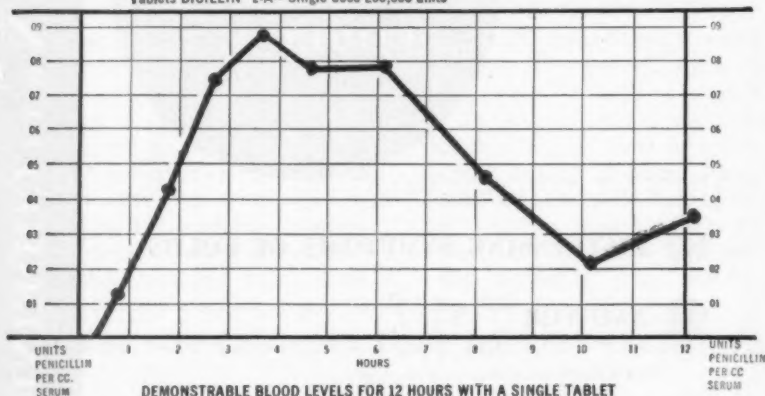
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*Trademark

Congressmen agree that the responsibilities of a practice make it difficult for doctors to break away voluntarily to enter the services. So some kind of screening and compulsion may remain necessary.

But Congress will demand that the Pentagon stop *wasting* medical talent and that the number of M.D.'s per thousand personnel be cut from four to less than three. If the draft is continued, the \$100 a month pay equalization feature—commonly referred to as “incentive pay”—will probably be continued, too.

Two other bets for favorable legislative action this year are these:

¶ There'll probably be an appropriation for continuation of the Hill-Burton program. Congress and doctors seem to agree that a good job is

being done, though there's some doubt whether the neediest areas are getting enough of the new facilities. At any rate, Congress is likely to vote what it did last year: around \$75 million—not the \$150 million authorized by the law and endorsed by the Magnuson Commission.

¶ Congress will almost certainly vote a fairly generous appropriation for the Public Health Service. Expectation is that it will exceed last year's \$302 million.

In sum, this adds up to considerably less than a bang-up legislative harvest for physicians. But taking the good with the bad, the prospect for 1953 is by no means gloomy. At least, there should be some easing of tension in a previously embattled profession.

END

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Pneumococcal, viral,
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Storm Over Danbury

[CONTINUED FROM 76]

The managers' arrangement with Dr. Conway, as announced later, was this: He would become executive chief of staff and director of surgery at Danbury Hospital at a starting salary of \$16,000 a year. He would continue his other outside work and would also practice privately in Danbury. In anticipation of returns from this private practice, his salary would be cut to \$14,000 the second year and \$12,000 thereafter.

In the spring of 1951, Danbury doctors heard about the Conway deal and protested. Such an arrangement, they told the public, violated a hospital by-law that no staff doctor should be paid for duties performed on behalf of the hospital.

The managers' answer was to call a special meeting of the hospital membership to consider changing the by-laws.

Advice from A.C.S.

At this meeting, held in July of '51, Walter Merriitt, as a member of the corporation, led the fight against the managers' proposal. His chief weapon was a letter from Dr. Paul S. Ferguson, assistant director in charge of hospital standardization, of the American College of Surgeons:

"The arrangement . . . of employ-

ing a paid chief of staff who is in competition with other members of the medical staff is an unhealthy one. . . . It would be our strong recommendation that the board . . . reconsider its proposed action and attempt to induce the medical staff to make the staff organization function properly."

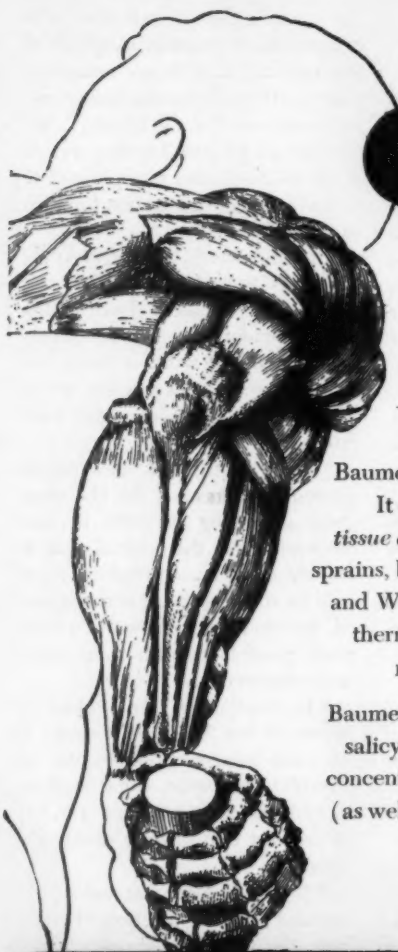
The vote was 84 to 66 *against* the managers' proposal.

Thereafter—amid a flurry of letters, statements to the press, and personal missionary work—events piled swiftly toward a climax for which both doctors and managers were girding:

¶ In August, 1951, newspapers quoted a spokesman for the managers as saying that the by-laws need not block the original plan to employ Conway. Instead of being paid by the hospital, it was suggested, he could be paid out of a fund made possible by gifts from prominent supporters.

¶ In September, Dr. Robert S. Myers of the American College of Surgeons inspected the hospital. As a result of his report, the college removed the hospital from the approved list and gave it provisional approval only.

¶ In November, just before the hospital's annual meeting of members, the managers announced the A.C.S. verdict in a newspaper statement and put the blame squarely on the medical staff. The doctors replied, in a paid advertisement, that the A.C.S. report had cited shortcomings on the part of management



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The "hyperkinemic" activity of Baume Bengué goes beneficially deep.

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Baume Bengué

1. Lange, K., and Weiner, D.: J. Invest. Dermat. 12:263 (May) 1949.

Available in both **regular** and **mild** strengths.

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also. This drew an answer from the managers, in another paid ad, reiterating that an "uncooperative" staff was at fault for all the hospital's ills.

New Record for Votes

The upshot wasn't exactly what the doctors had anticipated. Having pleaded their cause ardently, they felt confident of enough support from the membership of the hospital to elect some friendlier trustees at the November meeting. But they were soon disillusioned.

Where attendance at previous meetings had been at most around 150, this time nearly 550 members of the hospital turned up. Workmen from the contracting operations of President Dolan, and from the hat factories of Managers Lee and McLachlan, were much in evidence. The physicians' candidates for the board of trustees received 167 votes—more than the total cast at the previous special meeting. But the managers steamrollered their complete slate of trustees into office with a vote of 365.

Charged the doctors, after a hurried investigation: (1) The meeting had been packed with some 300 employes of several members of the board of managers. (2) All had been given one-year memberships within the last three months in return for \$5 contributions to the hospital. And (3) few, if any, of them had paid the \$5 out of their own pockets.

Said Merritt, addressing a public meeting later: "The managers, in order to get their way, bought the

votes they needed at \$60 a dozen."

The managers said nothing for two weeks. Then, on Dec. 4, 1951, the Danbury News-Times reported:

"The board of managers of Danbury Hospital has announced that Dr. Francis M. Conway has assumed his post as executive chief of staff and director general of surgery of the hospital with full staff privileges."

After that, the rupture between the managers and the staff doctors was complete.

Staff Without Status

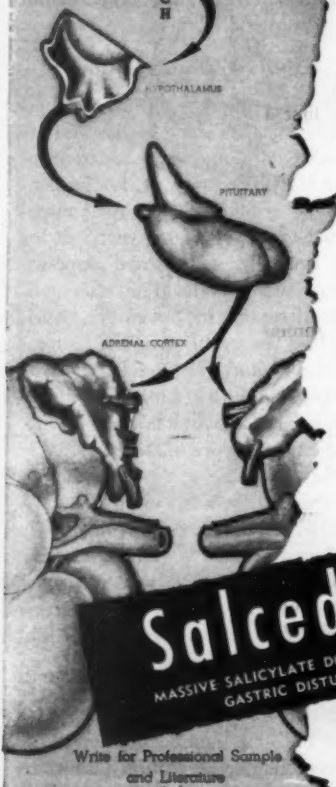
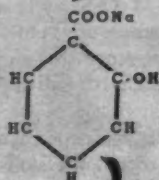
Technically, the medical staff had already lost its voice in hospital affairs. All appointments had terminated the preceding Oct. 1. The doctors had submitted their recommendations for the ensuing year, but for the first time no formal appointments were made. The managers' annual report, in November, 1951, omitted the traditional staff roster.

The doctors continued to use the hospital facilities, presumably subject to Dr. Conway's approval. Duty assignments were made by Conway without consulting the doctors.

Then, six months after Conway's arrival, a glimmer of hope appeared. Out of the blue, the board of managers asked Merritt to confer with a New Haven attorney and suggest "a program of cooperation" that might satisfy everybody.

Result: an enthusiastic "peace meeting" on June 10, 1952, at which the hospital membership endorsed a conciliatory resolution passed by

are



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*Proceedings Soc. Exp. Bio. Med. 1952, v80, 51-55, G. Cronheim, et al.

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the board of managers. The resolution proposed establishment of a committee of the board to maintain "close and constant contact with an appropriate committee of the staff." It recognized the staff as "an advisory agency" on all matters within its province. And it said, "The board and the executive chief of staff have agreed that the latter, while he continues to hold that office, shall refrain from the competitive practice of medicine in . . . Danbury."

'Harmony Restored'

Sometime earlier, postcards had been sent to the doctors, confirming their staff appointments for the year that had started eight months previously. After the "peace meeting," the Danbury News-Times heralded what had happened with a headline saying, "UNANIMOUS ACTION SHOWS HARMONY RESTORED BETWEEN MANAGEMENT AND STAFF."

But the alleged harmony was a mirage.

True, the two proposed committees were named; and they held a first get-acquainted meeting. But they never met again.

On the morning of Aug. 1, 1952, Dr. Nathaniel B. Selleck, who was assigned to medical service for that month, reported at the hospital. In the afternoon, he was informed that he had been removed from service by Dr. Conway's order. When Selleck asked for an explanation, Conway answered in writing: "Several names have been removed from what was the current medical list

and your name was one of them."

This, the doctors decided, was a matter for their liaison committee. So they sought further enlightenment from Conway and Dolan. They were still seeking, and getting no answer, when, on Aug. 14, Conway walked out of Danbury Hospital for the last time.

Not until two months later was it generally known that Conway's resignation had been in Dolan's hands on Aug. 15. It had not been accepted until further developments brought the row to its maximum pitch.

The story, as it gradually came out, was that Conway had threatened to quit early in August unless certain men were removed from the staff. Among them were said to be Drs. Booth and Selleck, who had been particularly critical of his regime.

The Showdown

4. Since a hospital governing board has final authority for decisions, it must also accept final responsibility for failures. Thus, when the staff and the board fail to agree—and when their deadlock becomes a threat to the institution they serve—the only reasonable solution may be to elect a new board.

The Danbury Hospital managers showed little talent for public relations. In precipitating the final stage of the conflict, they apparently never guessed they were stirring up a whirlwind capable of blowing them out of office.

Dr. Conway had been away from

the hospital for six weeks. Only the managers knew of his resignation, which they had not yet accepted. It was nearly time for staff appointments, and the physicians were wondering whether their list of recommended candidates would be ignored.

It wasn't completely ignored. On the evening of Sept. 29, 1952, Drs. Booth and Selleck, whose names were listed, got phone messages from the hospital. They were asked to attend a meeting of the board of managers next day, to discuss their reappointment.

"It was another by-passing of the committee set-up endorsed by the managers themselves," says Booth. "Evidently, Dr. Selleck and I had been singled out for special consideration. Remembering the reported threat made by Dr. Conway, we didn't like it. We sent a special-delivery letter to Mr. Dolan, requesting postponement of the meeting until we could get advice as to whether our committee shouldn't be consulted first."

Suspensions Come Fast

At noon on Oct. 1, Booth and Selleck got their answer by registered mail. Van Lenten, as secretary, wrote that the board had voted to deny them all hospital privileges. Their suspensions were to begin that midnight and were to last "until cause is shown why you failed to appear as requested at this special meeting."

This was the ultimate indignity,

and the fifty-odd members of the Danbury Medical Society took quick note of it. Says Dr. Francis B. Woodford of Ridgefield, president of the society:

"The suspensions convinced us there was no longer any hope of agreement. The managers had broken the pledge they gave at the June 10 meeting. And because the suspensions were obviously in retaliation for criticism of the board, no other staff members could be sure they wouldn't get the same treatment.

"The best thing we could do—for the community, the hospital, and ourselves—was to force the issue. And the sooner the better."

Public Aroused

The managers couldn't have chosen two victims better fitted to arouse public sympathy. Both suspended doctors had been on the hospital staff twenty-five years or more. Both were natives of Danbury, widely known, well liked, thoroughly reputable. The story of their dismissal made headlines far beyond the Danbury Town limits.

Within a week, the local dental and nursing organizations and a number of civic groups had called special meetings to demand immediate reinstatement of the two doctors. The board of censors of the county medical society, meeting at Bridgeport, urged the managers to reconsider. The state medical society appointed a committee to investigate. And the general hospital at

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1. Council on Pharmacy and Chemistry, American Medical Association, New and Nonofficial Remedies 1958, Philadelphia, J. B. Lippincott Company, 1958, p. 311.

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PATCH**



CANINE CRETIN Courtesy Lester R. Dragstedt, M. D., Chairman Department of Surgery, University of Chicago.



HUMAN CRETIN Courtesy C. E. Benda, M. D., from *Mongolism and Cretinism*, New York, Grune & Stratton, Inc., 2nd ed., 1949.



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New Milford, seventeen miles north of Danbury, speedily made full privileges available to Booth and Selleck.

The board of managers inadvertently helped the doctors' cause, too, by sharpening public indignation over the fate of hospital patients of the suspended men:

Dr. Selleck had two obstetrical cases scheduled for the hospital at about the same time. One patient was a socially prominent friend of the Dolans.

Dolan personally gave orders that Selleck be permitted to use the hospital facilities, despite his suspension, in this one case. But he refused to extend the dispensation to include the second patient. Newspapers, reporting this incident, underlined the fact that the second expectant mother occupied a less prominent place in local society than the first.

Dr. Booth had just completed the first stage of a major two-part operation when he was suspended. The patient and his family appealed to the board of managers to let Booth finish the second stage. When permission was refused, the patient was taken by ambulance from Danbury Hospital to New Milford; and Booth completed the operation there.

The Doctors' Stake

Confronted by growing criticism from the public, the board of managers offered Booth and Selleck a hearing on condition that they explain their failure to attend the Sept. 30 board meeting. But Booth

and Selleck refused the gambit; future negotiations, they insisted, were in the hands of the Danbury Medical Society.

"It's no longer a problem concerning Dr. Selleck and myself," Booth asserted. "All the doctors of Danbury have a stake in the outcome."

At last, on Oct. 10, Dolan announced crisply: "Dr. Conway's resignation was accepted this week." He would give no further details.

In succeeding days, both the doctors and the managers talked about bringing in a mediator from some other hospital to straighten out the mess. The Connecticut Hospital Association and the State Medical Society offered to appoint conciliators. But—with another annual meeting coming up on Nov. 17—nothing was decided.

Meanwhile, public opinion had crystallized. A random sampling of Danbury talk during this period:

¶ From a non-medical professional man: "The doctors started off on the wrong foot, but the hospital managers have done even worse. My wife had two Caesareans in Danbury Hospital. She's going to have another next month—in New York."

¶ From a taxi driver: "I drive a lot of people who work at the hospital. Nearly all of them figure the doctors have been getting a raw deal. Me, I agree."

¶ From a hotel manager: "It's bad for the town and bad for the town's reputation. During the last few days, we've had guests from Chicago,

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Denver, and San Francisco who'd read about it 'way out there."

¶ From a restaurant owner: "My daughter's in training at the hospital nursing school, and she's afraid the school will lose its standing if this goes on. All the girls think Dolan and the others are to blame."

Open and Shut

More than 750 people jammed the small Elks Auditorium the night of Nov. 13, 1952, for an open meeting sponsored by the doctors. A minister, civic club officers, two physicians, and a scattering of men and women from the audience talked. Only the managers, who had been invited to attend, were not heard from. Resolutions, adopted unanimously and enthusiastically, called upon the managers to reinstate Booth and Selleck and to accept the conciliation offer of the state hospital and medical organizations.

Then, three days later, came the annual membership meeting. Fifteen of the forty-five hospital trustees (who serve staggered three-year terms) were seeking re-election; among them were four members of the board of managers, including Dolan and Van Lenten. An "independent" group of members submitted an opposition slate, headed by Merritt and endorsed by the doctors.

This time, a normal quota of 152 members was on hand to vote. Possibly because of criticism leveled at the 1951 meeting, no unusual number of new \$5, one-year members attended. Election result: Dolan and

Van Lenten, along with the other holdover trustees, were swept out of office by a vote of 94 to 58; the "independent" candidates were swept in.

"A decisive repudiation of management's past policies," commented Merritt, "and a remarkably accurate reflection of public opinion."

It was, in effect, a clean sweep. Vice-President Biggs and Treasurer Hooper weren't up for re-election as trustees; but they declared themselves out of the running for office or for the board of managers. So did other managers, including Executive Committeemen McLachlan (who had interrupted a Bermuda vacation to fly home to support Dolan) and Lee.

Dr. DeKlyn sums up the doctors' reaction in these words: "It was a complete victory, better than we'd dared hope for. But we're not celebrating. The fight caused too much bitterness, too much damage . . . I think everyone engaged in the row learned a simple lesson the hard way: that *no hospital can afford to let minor disputes go unsettled*. Staff and management must deal with them, frankly and firmly, as soon as they arise."

The newly constituted board of trustees moved immediately to reorganize the hospital administration. Pausing only to elect a president pro tem, a secretary, and a partial board of managers (including Merritt), the trustees:

¶ Restored hospital privileges to Drs. Booth and Selleck by the sim-

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ple means of reappointing *all* the previous year's staff members;

¶ Named a committee to choose and screen candidates for the salaried post of director, with over-all authority in hospital administration;

¶ Appointed Dr. Nathaniel W. Faxon of Boston as consultant "to make a survey of problems and policies relating to the hospital"; and

¶ Began a study of proposed new by-laws, under which the medical staff would have a voice in all matters affecting it, and under which no staff member could be suspended without a hearing.

These measures, the trustees feel, should go far toward meeting the four essential points for harmony and efficiency that were emphasized in the course of the conflict. Thus:

1. Balance of power is to be stabilized by a professional director, trained and experienced in hospital administration.

2. With machinery set up for arbitrating disagreements, there will probably be little danger of extra-

neous disputes getting a foothold inside the hospital.

3. Nor, from now on, should either staff or management be tempted to employ pressure tactics to gain an advantage.

4. While making final decisions and accepting ultimate responsibility, the new board of managers will minimize the chance of failure by constantly seeking the advice and cooperation of the staff.

Observers believe a good start has been made toward unraveling the snarls that have hampered the hospital. Their chief worry: Does the defeat of the Dolan group mean that the hospital may now encounter tougher sledding financially?

One of the retired managers has this answer:

"It will not. There were fundamental differences of policy between the old and the new boards of managers, but there was a bigger fundamental agreement. Both were thinking primarily of the welfare of the hospital. We still are." END

Round Number

● We had discussed arrangements for her operation—coming a year after her husband's. Everything was settled but the matter of payment, and the woman brought this up herself:

"Will it be all right if I pay the same way my husband did?"

"Certainly," I said.

Later I asked my secretary how much the woman's husband had paid. The files showed the answer: Nothing.

—M.D., MASSACHUSETTS



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The Newsvane

Boycott Urged, to Combat Summary Staff Firings

Physicians should boycott hospitals that drop staff members without justifiable cause, suggests the *Norfolk (Mass.) Medical News*. Specifically, the publication is concerned with the current case of three M.D.'s refused reappointment at the Massachusetts Women's Hospital, allegedly because they "had expressed dissatisfaction with the care given to patients!"

Drs. Barker, Hand, and Janney, long associated with the hospital, were not reappointed by the trustees in 1951, contrary to the staff's recommendations. Subsequently, the Massachusetts Medical Society deplored "the summary dismissal . . . without due recourse to accepted and traditional hospital procedure," and urged that the doctors be reappointed. The hospital's trustees were notified of this action—but ignored it.

Again, in 1952, both the medical and administrative staffs of the hospital recommended the appointment of the three physicians. And again the trustees turned thumbs down.

Says the *News*: "Since lay persons are not qualified to pass on the

competence of physicians, trustees must be guided by professional advice . . . Trustees should never lose sight of this fact: The staff can operate a hospital without trustees; trustees cannot operate a hospital without a staff."

The article cites the boycott of the Bay City (Mich.) General Hospital by its staff physicians last June, after the city commissioners voted to let osteopaths practice there. As a result of the boycott, it points out, the hospital census and receipts dropped until "the commission had no choice but to throw the osteopaths out . . .

"Obviously, then," concludes the *News*, "both the staff of the Massachusetts Women's Hospital and the Massachusetts Medical Society can enforce their request for reinstatement of the three staff physicians. This growing tendency of trustees to tell the staff what it can and cannot do must be discouraged."

Private, Public Medicine In Skirmish Over Clinic

Where does private medicine end and public health begin? An incident in North Carolina has added new fuel to this old controversy.

The issue developed when a

district health officer, Dr. B. B. McGuire, announced that there was evidence of a large number of heart disease cases among young school children in Elizabeth City. McGuire said he was calling in a qualified heart specialist to conduct a diagnostic clinic at minimum fees.

Dr. Zack D. Owens, Elizabeth City councilor of the state medical society, labeled this plan an "invasion" of private practice; and he carried the battle to the society's executive council. There, he pointed out that an annual, free pre-school clinic is conducted in Elizabeth City by private physicians. And he added that the city's medical men felt McGuire had overstated the case; they saw no evidence of a "public menace." Moreover, he said, Mc-

Guire's "qualified" heart specialist was a "self-styled" one.

As a result of Dr. Owens' testimony, the state society backed the local doctors in condemning the clinic. Faced with this opposition, McGuire has so far failed to put his plan into effect.

West Coast Doctors Rebuff Closed-Panel Plans

There's been some optimistic talk about the future of closed-panel health plans lately. But there's also been some harsh criticism of such plans, which generally provide health services through a network of group practice centers. Three recent examples of opposition (all from California): [MORE→

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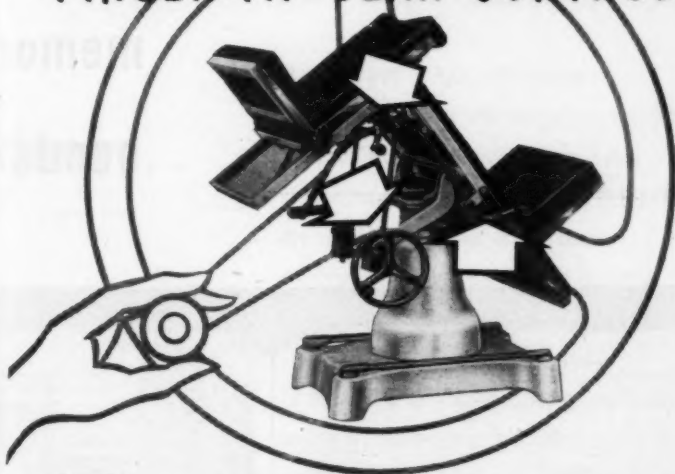
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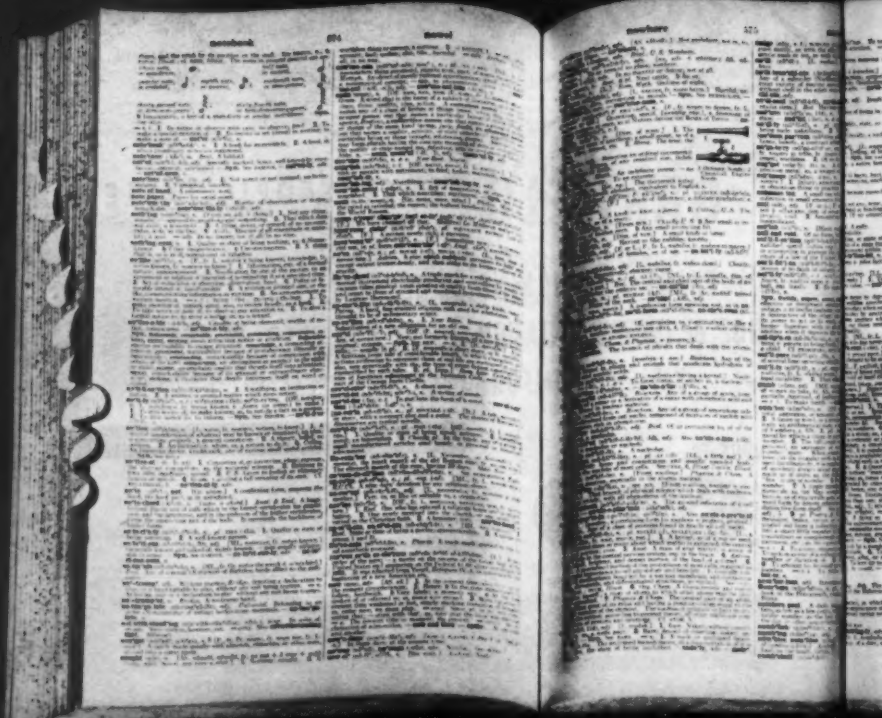
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¶ The San Francisco County Medical Association has voted 832 to 26 against a health plan proposed by that city's Central Labor Council. [For a full discussion of the projected plan, see November, 1952, **MEDICAL ECONOMICS**, page 180.] And the doctors intend to make their decision stick: They voted 776 to 79 to give medical service only to society-approved voluntary health plans. Their twofold objection to the labor-sponsored project: (1) it would not, in their opinion, allow patients free choice of physicians; and (2) the union insisted upon having some voice in setting fees.

¶ Dr. David de Kruif, son of Paul de Kruif, has quit the Permanent Health plan. "Its streamlined efficiency kept him from continuous contact, from follow-through, with his patients," explains the physician's father. In the past, the senior de Kruif has written of the Permanent plan in glowing terms. But today he concludes that "we cannot

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have a real personal physician in a closed-panel prepaid insurance plan where the doctors are hired hands, not free."

¶ Stating that closed-panel plans "look good on paper," President Wilbur Bailey of the Los Angeles County Medical Association insists that they're far less inviting in reality. Many of them, he maintains, afford merely "once-over-lightly, so-many-an-hour, assembly-line methods of treatment."

Dr. Bailey's main objection to such plans: "Not only does the patient lose free choice of physician," but often he is allowed "little or no voice in the selection of the plan" itself.

"Thirty-seven per cent of the people of the United States no

longer have the freedom of choosing their own doctors," he points out, in his county society bulletin. "Some 20 per cent are taken care of by the Government, 2 per cent by eleemosynary institutions, and 15 per cent more have their plans chosen for them as 'fringe benefits' by their employer, or, most frequently, by a labor union representative." And when the patient doesn't do the choosing, he adds, he may get the cheapest plan rather than the best.

Local Doctors Take Over Blood-Bank Coordination

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In the coal industry 5,000 privately managed coal companies compete with one another. When one company develops more efficient methods, the rest can keep pace only by striving to improve even

further. No wonder that, with his modern machines, the American miner's daily output is 4 to 24 times that of any miner in Europe or Asia—most of whom work in government-controlled coal industries.

Just as competition spurs you on to trying harder—competition goads the individual company to deliver products that will out-sell. And competition keeps a whole industry on its toes, cutting distribution costs, opening new outlets, delivering better products.

Competition—not government control—has already made America the most productive nation on earth. Competition—not regimentation—points the way to ever greater plenty for all of us.

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cians: How can they keep tabs on the total amount of available blood in their area?

Westchester County (N.Y.) physicians have come up with a solution. They've established their own coordinated inventory of the county's fourteen separate banks.

The medical society's registry "serves as a clearing house for all blood units in excess of current needs in each hospital," explains Executive Secretary Boyden Roseberry. Each morning, he explains, hospitals with a surplus of blood units telephone the figures to the registry. In this manner, the amount and types of blood available at all banks are constantly on record. And the registry offers a clock-round switchboard service. Result: one continuous, time-saving source of information on Westchester's dispersed blood supplies.

M.D.'s Adopt Dramatic Self-Policing Plan

The average grievance committee sits back and waits for complaints against doctors. But Phoenix, Ariz., physicians have now embarked on a more active self-policing project; they've set up a "committee to aid in maintenance of high ethical standards," aimed at "disclosing and correcting . . . incompetence or unethical conduct" of local M.D.'s.

Among the specific duties of the watchdog group, headed by Dr. Paul Case:

¶ It will "determine infringe-



Paul Case

He'll expose money-grabbing

ments" of the ethical code and recommend "corrective measures."

¶ It will "seek out and expose" mercenary physicians.

¶ It will try to keep physicians from accepting cases that are beyond their "skill and experience."

¶ It will encourage hospitals to demand that all medical men meet the high standards of work the institutions "now require in the fields of surgery and obstetrics."

According to Dr. Leslie B. Smith, president of the Maricopa County Medical Society, there are some doctors who object to the watchdog plan. They complain, he says, that committee investigations are "infringements of their personal rights as free, rugged individualists."

But, says Smith, personal rights cannot be carried to the point where the public suffers. So, he adds, "it is



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better for our medical society to furnish the public properly supervised and competent medical protection than it would be for some unqualified political body to regulate our whole noble profession in order to correct the wilfully dishonest actions of the very few."

Calls Welfare Practice Socialized Medicine

Physicians who oppose socialized medicine but accept fees from welfare agencies are working at cross-purposes, says a committee of New Hampshire doctors. For, it states, "if we want to avoid socialization, we cannot deal in it. Welfare medicine is 100 per cent socialized practice."

The New Hampshire Medical Society's medical economics committee, headed by Dr. Norman Crisp, has taken this tentative position after a two-year study of the problem. "Welfare-medical relationships have never been satisfactory to most physicians," the committee points out. And it adds that the doctor's income from welfare work is smaller than might be supposed—less than 3 per cent of the average M.D.'s gross in New Hampshire. [MORE→]



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WELCH  ALLYN

What's the best solution to the problem? The committee apparently feels that there should be "a return to individual physician control of patients who are unable to pay." If doctors refused welfare fees, they would then be reverting to "true charity," according to Crisp. But, he adds, his committee is not yet ready to offer specific recommendations; its policy isn't "sufficiently crystallized."

Who Gets Cabinet Health Post—If and When?

If Congress decides to set up a new Cabinet health post, who'll get the job as first Secretary of Health and Welfare?

Speculation on this question centered last month around two per-

sonalities: Mrs. Oveta Culp Hobby, the newly appointed Federal Security Administrator; and Dr. Franklin D. Murphy, Chancellor of the University of Kansas.

In her pre-Inauguration statements, Mrs. Hobby consistently refused to commit herself on health matters—except to say that she's against socialized medicine and completely in agreement with Eisenhower's conservative campaign statements on health. As a result, physicians don't know much about her as yet. But they seem willing to *consider* her as a potential Health Secretary—which is more than they would have done for the former F.S.A. boss, Oscar Ewing.

Much more is known about Dr. Murphy's qualifications for the job. Although still in his mid-thirties,



Oveta Culp Hobby
She likes her



Franklin D. Murphy
Happy where he is



For **COUGHS** in

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he's already won a national reputation among fellow M.D.'s. Especially noteworthy has been his so-called "Kansas Plan" for licking the rural doctor shortage. In brief, this plan offers community-furnished quarters and equipment as an inducement to young physicians to locate in small towns.

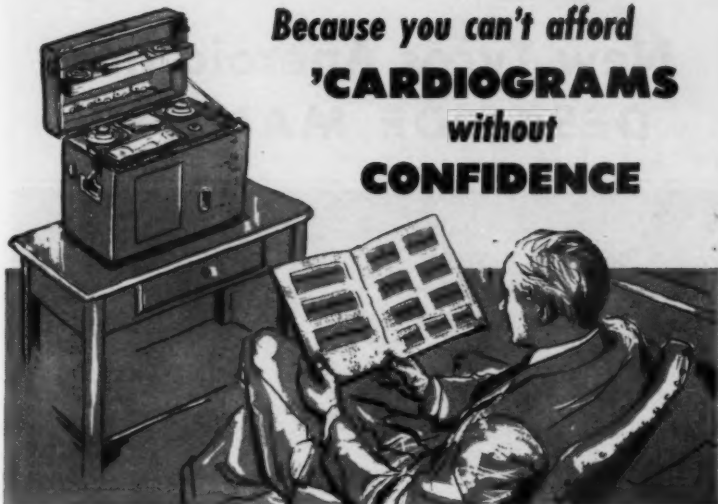
Is Murphy really in line for the still-uncreated Cabinet post? That's another question—and one that Dr. Murphy, at least, answers in the negative. He insisted last month that "nobody with any authority at all" had mentioned the matter to him. And, he told **MEDICAL ECONOMICS**, that included Eisenhower and his staff.

He attributed the current talk to a "highly speculative" article in *Time* magazine last October. And he declared: "I've never been happier at any job than at the one I've got now."

Civic Minded? These Physicians Are

Doctors are sometimes charged with civic apathy. But no such criticism is leveled against the M.D.'s of Dayton, Ohio. In a recent Community Chest campaign, they more than filled their quota—and did so even before the drive was officially under way.

The Montgomery County Medical Society was asked to raise \$14,500 among its 400 members, says its executive secretary, R. F. Freeman. And at the kickoff dinner for the campaign, the doctors were



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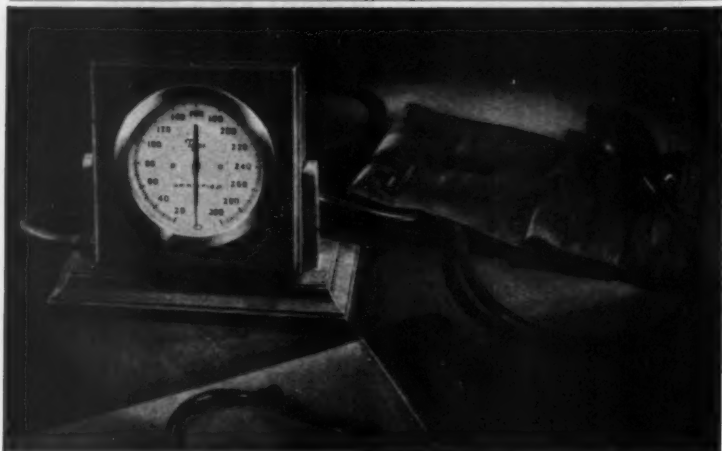
A new booklet, "Check Lists for Buyers of Electrocardiographs" offers guidance in evaluating the various instruments available. A copy will be sent gladly, without obligation.



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The movement of course, is the dependable, accurate Tycos movement. You can be sure it is accurate as long as the pointer returns within zero—an easy visual check. Our 10-year warranty states that it will remain accurate unless misused and, if thrown out of adjustment during the 10-year warranty period, we'll readjust the manometer only free, exclusive of replaced broken parts.

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SUPPLIED: Bottles containing 200, 500, and 1000 *Entabs*.

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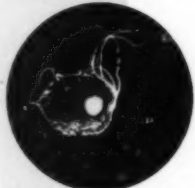
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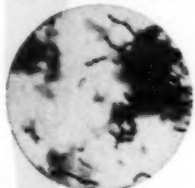
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MIXED INFECTIONS

able to announce that they had already pledged \$16,400—or 113 per cent of their quota.

At that same dinner, says Freeman, Dayton's attorneys and dentists had to admit they'd fallen short of their targets. Clergymen and osteopaths had exceeded their quotas—but, he adds, they'd failed to match the 113 per cent return of the physicians.

Study Indicates Ways of Cutting Hospital Costs

Are most hospitals run at peak efficiency? The answer, stemming from an as yet limited study of the situation, is no. A pilot survey, conducted by the Council on Professional Practice of the American Hospital Association, has already turned up dramatic examples of ways to improve administrative methods; and it has shown that these improvements can save the doctors' time and the patients' money.

The council made its initial check-ups in sixty hospitals, under the direction of Dr. Dallas G. Sutton. Under the prodding of this survey, various hospitals did these things:

¶ Cut a day from the average patient's stay by moving admission time from late afternoon to morning;

¶ Saved a day per patient by tightening the timetable of surgical operations; and

¶ Weeded out persons not in need of hospital care by requiring routine tests to be taken prior to admission.

The point to remember about this

efficiency study, says Dr. Albert W. Snoko of New Haven, Conn., in a letter to the *Journal A.M.A.*, is that improvements have helped reduce the cost of hospitalization "without impairing quality of service."

Three hundred hospitals, interested in accomplishing just this, have expressed interest in having their own methods put under the microscope. And the *Journal A.M.A.* comments editorially: "Physicians on the staffs of all hospitals are urged to take the fullest advantage of this new and promising attack . . . on the problem of the high and mounting costs of hospital care."

Are Doctors' Courtroom Fees Adequate?

Are doctors adequately paid for their courtroom appearances? Physicians and lawyers give far different answers to this question, according to a recent "representative sampling" of both groups in Connecticut.

Sixteen lawyers and eight doctors, all familiar with medico-legal problems, were interviewed by the state medical society's Committee on Expert Medical Testimony. In discussing major points of friction revealed by the survey, Dr. Louis H. Cohen, chairman of the committee, reports the doctors generally complained that:

1. They're underpaid for their court appearances, "since they suffer various losses which the lawyer does not seem to take into consideration." The physician, says Cohen,

in addition to examining the litigant, must prepare a report and study the pertinent medical literature. And he often has to cancel appointments in order to get to court. In addition, say the doctors, their bills "for fifty or one hundred dollars" are protested, "while the lawyer may collect many thousands of dollars."

2. They get too little cooperation from lawyers. All the doctor's preparation may be wasted "because a settlement out of court may be made at any time." Often, they maintain, the lawyer never even bothers to notify the physician of such settlements.

Several of the doctors interviewed said they strongly resent the need of repeatedly sending bills to lawyers, who frequently ignore them.

Angered at one attorney's "nonchalant disregard of his bill," one physician said he finally sued, to collect a \$75 fee.

Many doctors, reports Cohen, believe that when a case is settled, "lawyers take out their own fees before paying their clients, but leave it to the clients to pay . . . the doctor's bills." The M.D.'s particularly resent this practice, since they feel that "medical testimony should be considered a part of the lawyer's expenses, and paying for it should be his responsibility."

In general, says Dr. Cohen, physicians want "neither excessive nor niggardly fees but fair compensation for their work, whatever the outcome." They feel that fees should be determined in advance and "cal-

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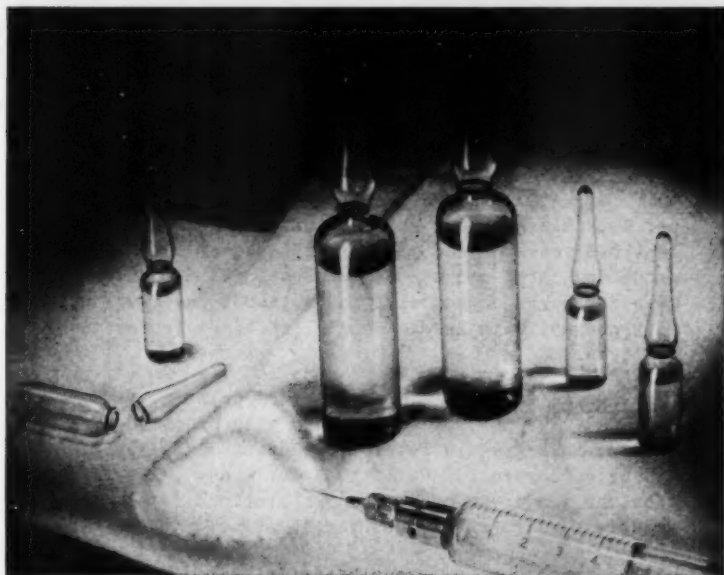
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A NEO-PENIL* CASE HISTORY

Bronchiectasis: Preparation for surgery

Patient: Mr. A.C., age 52, admitted to the hospital November 10. Eleven years' history of bronchitis. In the last 5-6 years he had periodic attacks of severe cough, producing large amounts of purulent, fetid sputum. He had "caught a bad cold" in September and was feeling very poorly, with severe cough, copious expectoration and fever.

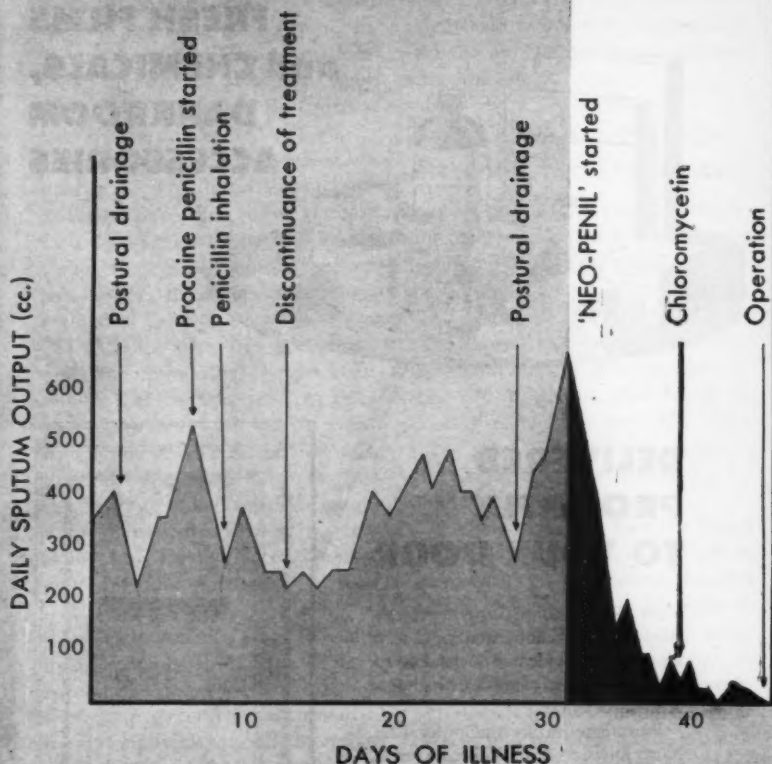
First course of treatment: After sputum cultures were obtained, the patient was treated with procaine penicillin, intramuscularly, 150,000 units daily for 5 days and streptomycin 0.5 Gm. t.i.d. for 4 days. In addition, he was given penicillin inhalations for 6 days. Postural drainage was employed throughout the treatment.

Response: The amount of expectorate decreased but slightly.

On December 4, the patient was transferred to the Department of Thoracic Surgery of a larger hospital, for operation. Bronchoscopic examination revealed marked bronchiectasis in all segments of the left lower lobe. The upper lobe, including the lingula, showed no abnormality. The sputum volume was now 600 cc. per day.

Second course of treatment: In the hope of reducing the sputum volume before operation, the patient was given 'Neo-Penil', intramuscularly, 1 million units the first day, 1 million units b.i.d. the second day, and 1 million units t.i.d. thereafter. Postural drainage was reinstituted.

Response: After 6 days, sputum volume was reduced from 600 cc. to 50 cc. per day. At this time sputum culture revealed penicillin-resistant bacteria and Chloromycetin was given, 0.5 Gm. every 6 hours for 5 days. The sputum volume was further reduced, and it was felt safe to operate.



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'Neo-Penil' is a new, long-acting derivative of penicillin, which concentrates in the lung and sputum. It is available at retail pharmacies in silicone-treated vials of 500,000 units (single-dose) and 3,000,000 units (Multi-Dose).

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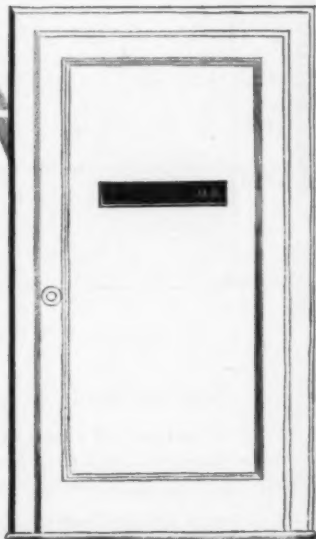
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culated on a fair per hour basis [including] all time in court, whether spent in testifying or not [and] independent of the amount of damages requested or awarded." Such fees, they add, should be "guaranteed by the lawyer."

But the lawyers themselves appear to be equally critical of medical men. According to the committee's findings as reported in the Connecticut State Medical Journal, the lawyers have two major complaints:

1. Medical charges are exorbitant. The interviewed lawyers maintained that doctors tend to overcharge for their services in court. And many M.D.'s allegedly refuse to reduce fees, even when the litigant fails to collect enough to pay trial expenses. Resultant impression: Many doctors "are interested only in 'grabbing money.'"

2. Physicians "have little . . . interest in the client . . . or in seeing justice administered." According to several of the lawyers, says Cohen, doctors in general "have less civic interest and sense of obligation than any other professional group." Maintaining that they, as attorneys, "accept indigence cases as a duty," the lawyers felt that "doctors considered court work in such cases an infringement of their rights rather than an obligation."

How can such conflicting points of view be resolved? Stressing the need for "instruction and discussion," Cohen suggests that an attack on the problem be made by a joint

committee of physicians and lawyers. He feels that such discussions might lead to concrete proposals to end the antagonism between the two professions.

New Leaflet for Patients Promotes Fee Discussion

In the belief that misunderstandings can be avoided if patients are prompted to "inquire about fees and services in advance," Vanderburgh County (Ind.) doctors have prepared a new leaflet for general distribution. Designed to supplement the A.M.A. plaque that hangs in doctors' offices, the pamphlet (like the plaque itself) invites questions and encourages fee discussion. Its chief points:

¶ The physician's fees are based "not only on the time and effort spent with you, the patient, but also on the time and effort he spent in acquiring the skill, care, and judgment with which he serves you."

¶ "Doctors do much free work; but they believe it should be their choice, and not that of the patient, to decide when no payment is due or necessary."

¶ When bills are hard for the patient to meet "within the usual time," the doctor "will consider the circumstances and make satisfactory arrangements" for payment.

For the layman who questions the size of doctors' bills, the leaflet frankly highlights some basic economic facts: "The physician has an operating overhead expense that re-

quires a considerable portion of the money he collects from patients. He, too, must meet a payroll. He must buy and pay for valuable equipment, drugs and insurance . . . and he, too, must pay heavy taxes just like everyone else."

United Drives Defended As Fairer, Cheaper

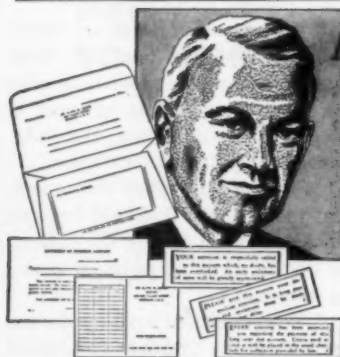
Many doctors have attacked federated fund-raising as an infringement of free choice in donating to charity. This viewpoint was expressed by Albert Q. Maisel in a recent *Cosmopolitan* article (see *MEDICAL ECONOMICS*, October, 1952, page 220).

But the defenders of lump-sum giving have arguments on their side, too. One of them, Vice President

Alex F. Osborn of the Community Chests of America, has now come up with answers to Maisel's criticisms. Here are some of the major charges and replies:

¶ Maisel's charge: Federated fund-raising is often uneconomical; a Michigan drive, for instance, spent \$271,949 over an eighteen-month period and distributed just \$1.3 million. Osborn's reply: The man who headed the Michigan appeal, Floyd A. McCartney, calls this "a flat lie," and adds: "Our campaign and administrative expenses have been about six per cent."

¶ Maisel's charge: When the National Association for Infantile Paralysis refused to join with The Torch Fund (Detroit's single-drive) Torch funneled its charity dollars



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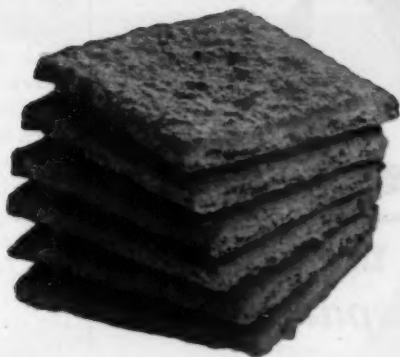
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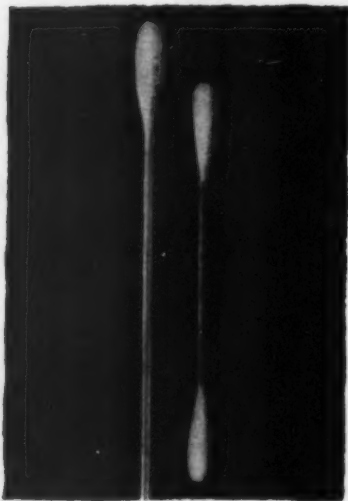
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1/2-hour before meals or when hungry. A full glass of water  must be taken with each wafer to insure proper bulk formation. Not more than 8 wafers should be taken in a 24-hour period. MELOZETS are contraindicated in the presence of intestinal obstruction. MELOZETS are packed in 1/2-lb. boxes, containing approximately 25 methylcellulose wafers.

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into a propaganda effort to make people believe money donated to Torch would help combat polio. Osborn's reply: Though the polio foundation rejected Torch money, Torch helped to fight polio by distributing money to proper local health organizations.

¶ Maisel's charge: A federated drive was attempted in Midland, Mich., in 1948, and all organizations but the polio fund took part. The subsequent, separate March of Dimes failed to meet its goal. Then polio struck, teaching Midland people "a lesson they will never forget." Osborn's reply: The 1948 polio-fund chairman in Midland, J. Lawrence Amos, agreed to take part in the single drive, and, through it, received his full quota. But national polio officials forced Amos to return the funds; then outsiders were sent into Midland to conduct the March of Dimes that failed. As for the epidemic, Osborn maintains that this of itself is not a valid argument against federation.

Osborn's defense of the federated approach has been supplemented by a second *Cosmopolitan* article—this time in favor of lump-sum giving. Author Morton Sontheimer's chief argument: The single drive is "an attempt to bring order out of chaos."

As evidence of "chaos," Sontheimer points to Providence, R.I., with 1,000 charity drives in one year. And there as elsewhere, he says there's a major campaign by a national organization every month of the year—except in summer. [MORE→]



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Federated fund-raising, adds the writer, allocates funds on the basis of need. He points out that too many big organizations now battle for the charity dollar, and that the money is therefore not equitably distributed. In 1950, for example, \$27 million was raised for polio, \$14 million for cancer, and \$4 million for heart disease. But, he points out, in that year "only 1,686 people died of polio. For every one who died of polio, 125 died of cancer, and 318 of heart disease."

Such figures show, Sontheimer argues, that when individual drives are conducted, the charity dollar is split to give the lion's share to the fund with the most attractive public relations. This is seldom, he says, the fund with the greatest need.

Says Youth Should Have More Say in Medicine

Young doctors should be given a greater voice in organized medicine, says Dr. Gervais W. McAuliffe. As president of the New York County medical society, he points out that his own association has placed the accent on youth during the past five years.

By way of contrast, he then cites the specialty boards as examples of organizations where "the palsied hands of age" have impeded progress.

The American Boards, like most medical societies, would benefit, says McAuliffe, "from a transfusion of youth." Admitting that a young doc-



Gervais W. McAuliffe
Don't stifle young doctors

tor's judgments "are apt to be intuitive," he insists that this is no reason for stifling them. After all, he adds, the young physician "should have equal voice in the formation of policies and decisions which will affect him—and him alone—in the future."

How to Tell a Cancer Victim He's Dying

Too many family physicians abandon the dying cancer patient, say two Chicago doctors, Samuel G. Taylor III and Danely Slaughter, in a special report to the A.M.A.

When such physicians view the case as hopeless, they turn the patient over to an X-ray man, tell the family they can do no more, and see the patient as little as possible, "acting merely as a dispenser of

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Abbott

1. McGuire et al. (1952), J. Antibiotics & Chemo., 2:281, June.
2. Heilman et al. (1952), Proc. Staff Meet. Mayo Clin., 27:385, July 16.
3. Haight and Finland (1952), New Eng. J. Med., 247:227, Aug. 14.

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narcotics," says the report. So, it adds, despairing patients frequently wind up seeking help from quacks.

The root of the problem, according to Taylor and Slaughter, is the difficulty physicians encounter in confronting the patient and telling him the facts. To help the family physician make the best of a bad situation, they make the following suggestions:

¶ If the patient is the head of a family, he must certainly be told where he stands. But this needn't be a blunt disclosure. Instead, the report advises saying something to this effect: "You have a return of the disease for which you were operated on; the disease is progressive, but we'll do all we possibly can to keep it in check and keep you in relatively good health for some time."

¶ A child or a "sensitive elderly woman" should not be told the truth. Taylor and Slaughter recommend advising such patients that they'll be worse before they get better. Otherwise, "they will lose faith and may go into a very depressed or antagonistic state."

¶ Patients who are "intelligent but fearful" suspect the worst but hope for the best, as long as there is some doubt in their minds. And "this doubt must be nourished."

¶ The patient's family must be told the situation. If the patient is to be kept in the dark, "the deception must be explained to the family, that they may cooperate with the physician," the report advises.

It adds that relations with a cancer victim's family are important in



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other respects, too. The family may hear of a cancer "cure," for example, and look to the family doctor for action. In this event, say the reporting physicians, the doctor should "investigate . . . for the family and not appear to be prematurely prejudiced."

But what if a patient, against his doctor's advice, runs to a quack for help? The physician should be tolerant of such hysteria, Taylor and Slaughter emphasize. "In our experience," they add, "as many physicians with incurable cancer attempt relief from unproved or obviously false forms of therapy as do those with no knowledge of medicine."

Most Emergency Calls Are The McCoy, Study Finds

When a patient telephones for emergency medical care, is he *really* in the grip of an emergency?

Some physicians insist he seldom is. And so they argue against the widespread establishment of emergency-call bureaus. The switchboards of such bureaus, they say, are likely to be flooded with non-emergency calls.

A recent survey of an actual situation, however, tends to show that patients do know an emergency when they see one. The study, made by the Medical Society of the County of New York, covers eight months of rush calls (2,461 of them) made to the society-sponsored Doctor's Emergency Service. Its finding: Most calls are for "legitimate medical reasons." [MORE→



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1. Behrman, H. T., Combes, F. C., Bobroff, A., Leviticus, R.: *Ind. Med. & Surg.* 18:512, 1949.
2. Turell, R.: *New York St. J. M.* 50:2282, 1950.
3. Heimer, C. B., Grayzel, H. G., and Kramer, B.: *Archives Pediat.* 68:382, 1951.

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About three-quarters of the calls were made in cases of accident or of respiratory, gastrointestinal, neurological, or cardiac attack. The number of calls from hypochondriacs or for trivial reasons was "not excessive." Only one in twenty calls involved alcoholic or drug addicts.

Summing up the survey findings, the society's executive secretary, Robert D. Potter, says: "Before a patient will apply for emergency medical care, he is really ill. His judgment as to the seriousness of the illness is usually justified." Thus, concludes Potter, "twenty-four-hour emergency call plans operated by county medical societies perform a most useful public service."

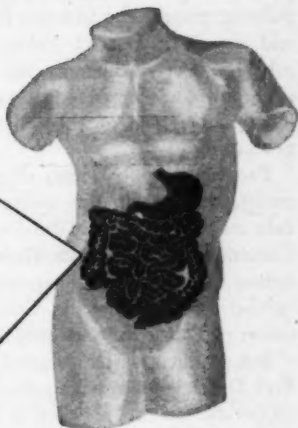
Parking Tickets Endanger Night-Call Service

The success of Chicago's two-year-old emergency night-call service is being jeopardized by the inability of doctors and police to agree on parking privileges. In some areas of the city, reports Dr. Robert R. Mustell, chairman of the service, an average of one out of two calls has resulted in a traffic ticket for the physician.

Initiated by the Chicago Medical Society, the service has been plagued by parking problems from its inception. The problem is particularly acute in three congested areas where few physicians live, and to which they must drive. When they're given tickets, doctors must lose considerable time in court, says Mustell, even though the charge is

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generally dismissed. As a result, many M.D.'s have resigned from the service.

Chicago traffic control, he explains, is supervised by two separate policing groups—the Chicago Police and the Park District Police. To solve the doctors' dilemma, the Chicago Police and the medical society have now agreed on the following procedure:

Participating physicians who get parking tickets while on emergency calls are to send them to the doctors' Committee on Night Calls. The committee then forwards them—after a careful screening—to the Commissioner of Police, who cancels them.

But so far, says Dr. Mustell, the Park District Police have refused to cooperate. So the problem is only

partially solved. The one way to a total solution, he concludes, "is for the City Council to pass the necessary ordinance" to insure proper protection for the doctors.

Finds Good Times Bad For Ulcer Victims

Here another pet theory goes up in smoke: the belief that ulcers take a higher toll in bad times than in good. This may seem a logical assumption, but it's not supported by the facts, says a dedicated researcher, Erwin L. Linn of Chicago.

What are the facts? Just the reverse of the common belief, says Linn: The ulcer victim literally can't stand prosperity. A check of the figures from 1900 on has shown Linn



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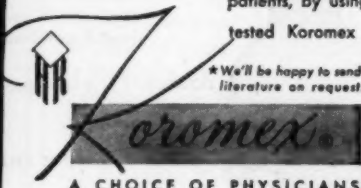
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AM PLUS

1. Youmans, J. B.: Deficiency Diseases, M.D., VI:523, (December) 1951, p. 533.
2. Boyd, J. D.: Is This Patient Well Nourished and Well Developed?, The Internist, (August) 1947, p. 360.

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a surprising correlation between prosperity and death from ulcers. The statistical patterns are not identical, he acknowledges, but the differences are small.

Why should death from ulcers be linked to prosperity? Linn, who is not a doctor, quotes medical authorities as saying that ulcers tend to heal when the victim's mind and body are at ease. It might follow, he suggests, that during a depression "the enforced leisure of unemployment or decreased activity of business in general" would serve to benefit the ulcer victim. And, by contrast, he says, a business pick-up would end the rest period.

Linn concedes this much to the popular notion: "Emotional strain" stemming from a depression may result in ulcer deaths. But he holds that his figures indicate that "emotional strains in prosperous years are probably still greater in their effect on ulcers."

Panel of Medical Experts May Help Speed Justice

What the doctor for the prosecution describes as a fracture, the medical expert for the defense sometimes terms a scratch. So, in the face of such radically conflicting testimony, the average jury often becomes hopelessly confused.

What's the solution? The New York County Supreme Court has high hopes for a plan it's now testing with the aid of the medical profession. By bringing in testimony from impartial experts, the project



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aims at abolishing opposing medical claims in personal injury trials.

Under the new pattern for cooperation between physicians and the courts, a panel of sixty to seventy experts in various branches of medicine is supplied by the Medical Society of the County of New York and the New York Academy of Medicine. An appropriate expert is assigned to a personal injury case whenever a pre-trial hearing (these are common in New York) shows vast differences in medical testimony.

In announcing the plan, Justice David W. Peck has emphasized that its purpose is "better and quicker justice, which amounts to juster justice." He points, also, to these prospective benefits:

1. The plan should have "a psychological and prophylactic effect" on the examining doctor's testimony, since it will be subject to review by higher authorities.

2. Conflicting medical testimony has agonizingly prolonged many personal injury trials. As a result, a number of well-qualified physicians have avoided time-consuming court cases. The medical panel plan may well solve this problem.

The panel has been established for a trial run of a year under a \$40,000 grant financed jointly by the Alfred P. Sloan Foundation and the Ford Motor Company Fund. Its budget is based on the assumption that the medical authorities will be called on to make some 500 examinations, for each of which the

doctors will be paid \$50. In addition, \$6,000 is allocated for a director to supervise the panel and to issue a year-end report on its work.

The experiment, says Justice Peck, may well be "a historic milestone in judicial progress—a pattern for the court system throughout the nation."

The New York Herald Tribune tends to agree. It notes, editorially, that the project attacks delay, "the main problem in the courts." And because of the program, the Herald Tribune adds, "the chances . . . are that a lot of trials will be avoided."

Life Saver—or Medieval Torture Instrument?

How do the anti-vivisectionists report on honest medical research? Here's an example, as printed by the Bulletin of the National Society for Medical Research in conjunction with the statement of Dr. Stafford L. Warren, the physician responsible for the work:

Under the heading, "The Case of the Medieval Instrument," the anti-vivisectionists discuss a series of experiments conducted, some years ago, by Dr. Warren and several associates at the University of Rochester Medical School. According to the National Humane Education Association, the "vivisectionists" performed "hundreds of flesh-crushing experiments" with an instrument called the Blalock press, which "looks like an implement used in a medieval torture chamber." The "only reason"



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for these experiments: The "vivisectors wanted to prove that other vivisectors had not been performing still other flesh-crushing experiments with sufficient accuracy and attention to detail."

And, the report adds, "the vivisectors are intent on this point—that room temperature changes the times at which animals die of torture and shock. The vivisectors seem little interested in making any other point."

Dr. Warren's statement, printed along with this anti-vivisectionist blast, notes, first, that the experiments under discussion were aimed at finding an answer to a wartime puzzle: Many a bombing victim would appear uninjured, although a limb was caught under wreckage. Once freed, however, the victim would go into shock and die.

And so, Warren explains, the experimenters used the Blalock press to test the effects of a trap that pins down a victim without seriously wounding him. The press was "carefully designed to put a constant, reproducible pressure on the leg muscles" of a dog without causing the animal to suffer.

As for the question of temperature, which apparently arouses particular anti-vivisectionist ire, Warren says: "The data obtained . . . led to an actual reversal of the previously accepted procedure of warming the shocked patient. These findings were of particular significance on the steaming Pacific Island battlefields, and jury-rigged refrigeration units were quickly and successfully pressed into service there."

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Memo from the Publisher

● What adjective would you use to describe **MEDICAL ECONOMICS**?

The word we used to hear applied quite regularly was "interesting." Today, almost as often, it's "authoritative."

Not long ago, for example, the A.M.A. put out a public statement on the amount of money being spent nationally for medical research. The most accurate report it could find on the subject, said the association, was an "authoritative" estimate from **MEDICAL ECONOMICS**.

Now, this particular label is one we have generally tried to shun. For a magazine gets to *be* authoritative, we're convinced, only by acting as if it *isn't*.

This means avoiding the pontifical, the theoretical, the dogmatic, the doctrinaire. It means avoiding too much emphasis on how things *should* be done; it means accenting instead how things *are* done.

How does this affect the articles you read? Well, take these recent examples:

¶ "When the Tax Auditor Comes" could have been a set of imperious commands for avoiding tax trouble. Instead, it was a documentary re-

port on the lessons learned by real-life physicians during their encounters with T-men.

¶ "Whatever Happened to Catastrophic Coverage?" could have been a thrust at the voluntary health plans for not providing longer-term benefits. Instead, it emerged as a how-it's-done story, describing the way some insurance companies were beginning to meet the need.

¶ "Our Free-for-All V.A. Hospitals" could have been a high-level discourse on veterans' care. Instead, it was a down-to-earth exposé of the admissions muddle at a typical V.A. hospital—the one in Erie, Pa.

¶ "Rx for Too Many Medical Meetings" could have been an exhortation for fewer demands on the doctor's time. Instead, it was a step-by-step narrative telling what Omaha physicians did to erase seventy-two meetings a year from their date-books.

¶ "Partnership Practice," our current series, could have been a compendium of Olympian advice. Instead, it's one case history after another, reflecting the actual experiences of more than 125 medical partnerships.

Thus, we don't set ourselves up as oracles. We simply pass along useful, interesting reports.

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bacterial infections



PENTRESAMIDE-250 speeds recovery from systemic infections, particularly when the invading organism is more sensitive to penicillin and sulfonamides combined than to either alone.

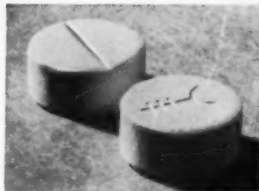


Simultaneous administration of three of the most soluble and least toxic sulfonamides reduces to a minimum the danger of renal toxicity.

Sharp & Dohme

Philadelphia 1, Pa.

SUPPLIED IN BOTTLES OF 60 AND 250 TABLETS (SLOTTED)



PENTRESAMIDE-250 Tablets combine sulfadiazine, 0.2 Gm., sulfamerazine, 0.1 Gm. and sulfamethazine, 0.2 Gm. with potassium penicillin G, 250,000 units.



Forgetfulness can be eliminated by the use of

IVORY HANDY PADS

When an untrained member of the family is called upon to care for a bedfast patient, it is not surprising if she neglects to carry out the doctor's orders adequately. This hazard can be eliminated by use of the Ivory Handy Pad on the subject.

Each of the six different Handy Pads contains 50 printed leaflets covering a supplementary home routine. By handing the patient a leaflet you minimize discussion time and, in addition, provide the indicated instructions in a permanent form. The Ivory Handy Pads contain only professionally accepted routine instructions.



Home Care of the BEDFAST PATIENT

**SAVES YOUR TIME . . .
HELPS YOUR PATIENTS**

YOU CAN OBTAIN—FREE—ANY OR ALL OF THE IVORY HANDY PADS

write, on your prescription blank, to IVORY SOAP, Dept. 2, Box 687, Cincinnati 1, Ohio



6244/100% Pure • It Floats

Ask for the Handy Pads you want by number.

No cost or obligation.

- No. 1: "Instructions for Routine Care of Acne."
- No. 2: "Instructions for Bathing a Patient in Bed."
- No. 3: "Instructions for Bathing Your Baby."
- No. 4: "The Hygiene of Pregnancy."
- No. 5: "Home Care of the Bedfast Patient."
- No. 6: "Sick Room Precautions."

